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Therapists' experiences of working with male clients with a history of childhood sexual abuse - implications for counselling psychology practice:
an interpretative phenomenological analysis

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Therapists' experiences of working with male clients with a history of childhood sexual abuse - implications for counselling psychology practice: An Interpretative Phenomenological Analysis

By

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Abstract

Background

Despite its high prevalence and long-lasting effects, male childhood sexual abuse (CSA) remains under-recognised which is reflected in the shortage of relevant literature. The existing literature suggests that mental health practitioners often feel undertrained, lacking confidence and competence working with male CSA survivors, and their attitudes frequently reflect societal preconceptions of masculinity and male CSA. The literature on CSA suggests that these factors, as well as engaging with clients' traumatic experiences can increase the risk of vicarious trauma in practitioners and may expose their clients to psychological harm. Despite the emotionally demanding nature of this work surprisingly little attention has been paid to the practitioners' experiences. This study aims to explore therapists' experiences of working with male CSA survivors to contribute to a greater understanding of therapists' needs.

Method

Semi-structured interviews were carried out with six therapists. The interviews were analysed using interpretative phenomenological analysis (IPA).

Results

Four themes were identified: "Impact of Societal Attitudes Towards Male CSA on the Therapists' Work", "The Challenging Nature of Male CSA Work", "Taking Care of Self" and "Caring About the Clients". The results indicated impact of societal perceptions towards male CSA on the therapists' work. The therapists experienced the work with male CSA survivors more challenging than with other clients which resulted in increased need to take care of themselves. The therapists also felt protective of their clients and wanted to provide them with a safe space.

Conclusion and implications

The work with male CSA survivors presents with specific challenges which affect the therapists' personal and professional lives. It is proposed that the research contributes to awareness of the complex nature of male CSA work. It provides support for specialist male CSA training and supervision, and it highlights the need for policy change to increase awareness of male CSA.

Table of Contents

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Introduction

Introduction

This section provides a short background to the research topic and it defines the terms used. It presents a summary of the existing literature of the broader areas of the topic which paves the path to the particular subject of this study. It also provides an overview of the existing work in the field that is closely linked to the research topic with the objectives of the study outlined. It provides a brief description of the methodology used. Finally, this section concludes with the description of the structure of the thesis.

Background

Male childhood sexual abuse (CSA) has been found to have major impact on the survivors' sexual and psychological development (Kia-Keating, Sorsoli, & Grossman, 2010). It has been associated with long-term negative effects across the lifespan, including problems in intimate and father/child relationships (Turmel & Liles, 2015) and increased risk of mental health disorders compared to child maltreatment survivors without CSA history (Turner, Taillieu, Cheung, & Afifi, 2017). Historically, male CSA has been under-recognised in general society and professional health-service provision (Holmes & Offen, 1996). This has partly been attributed to a societal reluctance to consider males in a position of sexual victimisation as opposed to sexual prowess (Kia-Keating et al., 2010) which has contributed to a false perception of CSA being a female issue resulting in greater focus on female survivors of CSA. Lack of recognition of male CSA has contributed to male survivors' difficulties to disclose, seek support and come to terms with their traumatic experiences (Garnier & Collin-Vezina, 2016).

Defining Childhood Sexual Abuse (CSA)

The existing literature reflects the presence of varying definitions of CSA which are at least partly the result of the complex nature of this phenomenon, including the many forms of CSA and the varying age limits of the victims that determine whether the sexual abuse was committed against a child or an adult (e.g. Lind, Aggen, Kendler, York & Amstadter, 2016). Some older definitions (e.g. Briere, 1992) which are cited even in more recent studies (e.g. Lev-Wiesel, 2008) define CSA as a sexual act between an adult and a child without considering sexual events between a younger and an older child or children of comparable ages at different stages of development.

For the purposes of the current study, the definition provided by The National Society for the Prevention of Cruelty to Children (NSPCC) has been chosen as it extends its reference to non-contact sexual abuse to the use of the internet, thus considering the rise of this form of CSA in recent years:

> Forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts, such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). This would include prostitution and sexual exploitation of a child for commercial or financial gain. The guidance also recognises that other children, and women, may be perpetrators of child sexual abuse (Radford et al., 2011).

Defining Trauma

Trauma is typically defined as exposure to single or multiple events where a threat or actual death, severe injury or sexual violation is experienced and is accompanied by intense fear, horror or helplessness (Sanderson, 2014). Due to the varying severity of trauma, several authors differentiate between single-event trauma or Type I Trauma and multiple events or complex trauma otherwise known as Type II Trauma (e.g., Terr, 1991). Rothschild (2000) divided Type II Trauma into further four subcategories: Type IIA, Type IIB, Type IIB (R) and Type IIB (Rn), with each subcategory indicating more severe trauma than the previous one and with the affected individual being less likely to separate, process and able to develop resources to become resilient. According to this categorisation of trauma, CSA is considered to fall under the most severe, Type IIB (Rn) trauma.

Understanding the severity of the trauma caused by CSA in many cases requires consideration of the impact of persistent and recurrent sexual, physical and psychological violations with abuse of power, lack of control, unpredictability and betrayal of trust. The absence of safety and protection poses a threat to the development of a variety of psychobiological defences and to the child's psychological integrity (Sanderson, 2014).

Defining Gender

Gender refers to the female or male sex when considered in relation to social and cultural differences, norms and expectations (Butler-Henderson, Dimitropoulos, Katte, Macpherson, & Bennett, 2018). Therefore, gender identity refers to the individuals' perception of themselves with regard to cultural meanings of female and male (Wood & Eagly, 2015). Traditionally, using a binary model, gender is linked to the person's sex assigned at birth and expressions conventionally associated with

that sex, e.g. males adopt traditionally masculine and females adopt traditionally feminine attributes and behaviours, including heterosexual attractions. Therefore, essentially gender binary suggests that there are two categories that all individuals can be classified into which are biologically determined, evident at birth, stable and in line with the individuals' experience and perception of themselves (Hyde, Bigler, Joel, Tate, & van Anders, 2018).

This conventional conception of gender is also represented in the psychology literature on CSA which will be evident in discussions on the prevalence of CSA and gender differences of CSA. However, as it will be discussed in more detail in chapter One, male CSA survivors frequently experience challenges related to their gender identity and to adopting traditional masculine roles. This raises issues with the traditional perceptions of binary genders and poses questions about people's gender being linked to biological sex and how stable and affirmed might people feel about their personal and social identity when their developmental path has been disrupted by sexual violence.

Prevalence of CSA

Reportedly, in the past year the estimate for sexually abused children worldwide was 12%, with 8% of boys and 18% of girls being sexually abused (WHO, 2019). The England and Wales 2016 crime survey suggests that 10.5% of girls and 0.6% of boys suffered any form of sexual abuse before the age of 16. These statistics were based on a sample of 20,582 adults aged 16-59. Reports on the prevalence of CSA in the UK and worldwide are estimates gathered from sources, such as children's services, police, independent enquiries and statistics offices. The prevalence rates have their limitations as they are influenced by several factors, e.g. varying approaches to sampling, data collection and definition of CSA which result in estimates ranging from

3% to 29% for males and 3% to 36% for females (Cawson, Wattam, Brooker, & Kelly, 2000).

Despite the limitations of CSA prevalence reports being widely acknowledged, a common consensus exists that male CSA is less prevalent than female CSA (Cawson et al., 2000). This can be attributed to several factors, such as lower disclosure rates in males (O'Leary & Barber, 2008), reduced likelihood of men labelling their experiences as abusive (Artime, McCallum, & Peterson, 2014), males being less likely believed about being abused (Von Hohendorff, Habigzang, & Koller, 2017) and methodological problems of gathering information on male CSA (Pereda, Guilera, Forns, & Gomez-Benito, 2009). For instance, questionnaires investigating male CSA have originally been developed from research on female CSA; thus, failing to adequately capture men's experiences (Pereda et al., 2009). This led O'Leary, Easton, and Gould (2015) to devise the Male Sexual Abuse Effects Scale (MSAES).

Gender Differences in CSA

Similar to the prevalence of CSA, gender differences are also considered difficult to establish due to methodological and definitional variations, and limited research comparing females' and males' experiences (Cashmore & Shackel, 2014). Although a wide array of mental health difficulties (Easton, Renner, & O'Leary, 2013; Jonas et al., 2007) have been reported in both genders, they have been found to vary in their intensity and form (Chandy, Blum, & Resnick, 1996; Soylu et al., 2016). Research also provides evidence for gender-specific difficulties, with girls more likely to engage in internalising behaviours, e.g. depression and disordered eating and boys more likely to engage in externalising behaviours, e.g. behavioural problems and excessive drinking (Hornor, 2010). Women have been found to suffer from complex and often unexplained physical health problems, eating disorders, insecurity and alertness, and men to suffer from problems with addictions and identity issues linked to masculinity

(Sigurdardottir, Halldorsdottir, & Bender, 2013). Moreover, Cashmore and Shackel's (2014) literature review indicated evidence for qualitative differences between boys' and girls' experiences, responses and recovery from sexual abuse.

Overview of Existing Research and Objectives of The Present Study

Academic and clinical literature on therapeutic work with male CSA survivors is developing unhurriedly. Most attention has been given to the work with female survivors of CSA or CSA survivors in general which in most cases includes females with a negligible male representation (Turner et al., 2017). The paucity of literature can be attributed to lack of awareness of the prevalence of sexual violence against boys underpinned by continued beliefs in traditional gender norms (Von Hohendorff et al., 2017) which is also reflected in clinicians' practice (e.g. Richey-Suttles & Remere, 1997) as will be discussed in more detail in chapter One. The present study endeavours to address the under-researched area of the therapists' work with male survivors of CSA; thus, increase awareness of male CSA.

There is a clear consensus across the literature about the challenging nature of trauma work (Hesse, 2002). Listening to stories of abuse and empathically engaging with the survivors' experiences can leave therapists open to vicarious traumatisation (Pearlman & Saaktitne, 1995). The existing literature indicates that therapists frequently feel undertrained to work with male survivors of CSA (e.g. Lab, Feigenbaum, & De Silva, 2000) and report lacking confidence and competence (e.g. Day, Thurlow, & Woolliscroft, 2003). Despite the emotionally taxing nature of this work, surprisingly little attention has been given to the therapists' needs. This study will also examine the therapists' experiences and perceived needs in working with male CSA survivors.

There is a starting recognition of the importance of investigating the nature, dynamics and the issues (e.g. help-seeking, building a therapeutic relationship) pertaining to the therapeutic work with men (Wade & Good, 2010). Given the support for qualitative differences between male and female CSA survivors' experiences (Cashmore & Shackel, 2014), it is possible that the therapeutic work with male CSA survivors would also be different, with authors (Corbett, 2016; Etherington, 2000) writing about the particular challenges of male CSA work, e.g. engaging clients in the therapeutic process and working with the impact of sexual aggression on the male psyche. The present study seeks to enhance the current understanding of the challenges of working with male survivors of CSA and the effects of these on the therapists.

Finally, the lack of engagement with the subject of male CSA rooted in conventional social conceptions of male gender roles impacts the survivors' lives and those around them, including the professionals working with them (Corbett, 2016). Consequently, as briefly highlighted earlier, the male survivors' lives are significantly altered and the support available to them is lacking. Therefore, this study aims to give voice to therapists working with male CSA survivors and indirectly to male survivors. It is proposed that the subject of this study and its social agenda is closely linked to counselling psychology's mission of promoting individuals' wellbeing (Vera & Speight, 2003) and its vision for counselling psychologists to be actively engaged in changing systems that restrict their clients' functioning (Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006). This allows the counselling psychology profession to adhere to its commitment to fairness, equality and social justice (The Division of Counselling Psychology).

Methodology

The present research will use Interpretative Phenomenological Analysis (IPA) to investigate therapists' experience of working with male CSA survivors. IPA has been extensively employed in the psychology field as it derives its data by paying close attention to the individual's lived experience (Smith, 2004). At the same time, it uses systematically interpretative work to identify meanings of lived experience not readily accessible to the individual (Smith & Osborn, 2007). It will be argued that IPA will allow for an idiographic exploration of each therapist's unique experiences embedded within a specific socio-cultural context (Smith, Flowers, & Larkin, 2009). The phenomenological underpinnings of IPA will help to gain access to the therapists' subjective experiences of working with male CSA survivors, and the hermeneutic foundations of IPA will assist in gaining closer understanding of the meanings the therapists attach to their experiences of working with male CSA survivors.

Outline of the Research

This introduction will be followed by Chapter One which will review the existing literature concerning masculinity and male CSA as well as work with male CSA survivors with a focus on the issues pertaining to work with this client group and the effects of these on the professionals working with them. Chapter Two will be divided into two parts. The first part will discuss the study's epistemological position and the methodology employed, and the second part will describe the methods used. Chapter Three will present the current findings, focusing on the impact of societal attitudes towards male CSA on the therapists' work, the complex nature of male CSA work, the therapists' identified support and self-care needs, and finally the therapists' experiences of needing to protect and keep their clients safe. Chapter Four includes the discussion of the current findings in relation to the already existing literature, limitations of the current study and implications for counselling psychology practice,

training, supervision and policy. Chapter Four will be followed by the complete list of references and the appendices.

Reflexive Statement

My interest in the subject of male CSA started with a friend's disclosure of CSA over a decade ago. His revelation came as a shock to me not only because he revealed a traumatic experience and because this involved a terrible violation of the parental role but also because this trauma was part of someone's history who I knew and perceived as stereotypically masculine without any overt expression of victimhood. In retrospect, I realised that I fell into the large proportion of society that is removed from the issue of male CSA and with a commonly held optimism bias that something like that could not happen to someone I know. Moreover, it revealed something about the male expression of painful experience that was somehow incongruent with my expectations. In an effort to support my friend and gain a better understanding of the subject matter I attended trainings, visited support groups and was given the opportunity to hear more stories of those impacted by CSA. I learnt how the complexity and the enormity of such an intimate act of violence perpetrated against young children without capacity to comprehend and tools to manage their experience ends up almost inevitably shaping their subsequent development and the life ahead of them. My interest in the subject area was further influenced by my experience as a trainee counselling psychologist in the first year of my training. One of my very first clients disclosed CSA after several months of therapy. As with my friend, I did not expect this experience to be part of my clients' upbringing which pointed towards a pattern of hiding once' traumatic experience. Although, by this time I was quite familiar with the subject of male CSA, it was the first time I approached it from the position of a helping professional which brought up feelings of uncertainty of how to best support my client with what appeared to be a guarded, shameful secret. The lack of

knowledge of how to work with my client's experience motivated me to look into the issue of male CSA further. Although, I came across research that explored male survivors' experiences, to my surprise research into therapists' experiences of working with male survivors of CSA was minimal. The literature available indicated lack of awareness and acknowledgment of the issue of male CSA not only by society but also by the therapists working with male survivors. This evident lack of interest appeared to be underscored by societal perceptions of maleness and the issue of victimisation being almost exclusively associated with female gender which partly related to my experience of a shock upon hearing about my friend's and client's experience. As a trainee counselling psychologist with my experiences and subsequent interest in the subject area, the evident gap in the literature and a prodding sense of needing to address the unaddressed, I was keen to engage with the subject of male CSA at a research level. As the area of therapeutic work with male CSA was even less explored than the subject of male CSA and I was interested to learn more about therapists' work with men who suffered CSA, how they worked with the inflicted experience of vulnerability and victimisation upon men and what their experience of working with the issue of CSA with male clients was like, I was keen to dedicate my research subject to the exploration of the therapists' experiences of working with male survivors of CSA. I believe that my personal and clinical experience of male CSA made me more interested, engaged and curious about the subject area. I also felt more passionate about addressing the lack of engagement with the subject. In my experience, hiding of their traumatic experiences made it more difficult to get a sense of the impact it had on them. This contributed to my wish to connect with the survivors' younger selves with the aim of getting closer to their experience and in turn gaining a better understanding of the nature of the therapeutic work. I believe that my previous experiences and wish to gain insight into the complexity of the issue of male CSA resulted in my choice of the method of enquiry. However, I wondered how the low societal awareness and engagement with the issue of male CSA impacted my

engagement with the subject matter. There was a clear evidence of impact on the survivors which manifested in hiding of their experience. It also showed in the lack of research engagement and availability of specialist therapeutic support. Therefore, it would just as likely had impact on my engagement with the subject matter and despite my curiosity, I wondered whether the socio-cultural complexity of the issue of male CSA contributed to my caution perhaps in the way I approached my research, the participants and the interview process.

Chapter 1 - Literature Review

Building upon the background research on the issue of male CSA, including the definitions, prevalence and gender differences covered in the Introduction section, the literature review focuses on the areas pertinent to understanding the current research and clinical climate of working with male CSA survivors. The role of gender and societal perceptions of gender appear to be central to the male CSA survivors' experiences of CSA and their ability to come to terms with their experience. Therefore, the literature review starts by examining different constructions of masculinity, their effects on males, their role in the male survivors' experiences of CSA and their impact on the survivors' disclosure and help-seeking. The literature review then examines the issues of working with men in therapy and male CSA survivors' experiences of support, paving the path to the essence of this study which is working with male CSA survivors. It reviews the existing literature on working with male survivors of CSA. It highlights the role of some of the socio-cultural issues impacting the work with male CSA survivors and considers the issues of vicarious traumatisation when working with this client group.

1.1 Masculinity and Male Gender Socialisation

The experience of sexual abuse raises issues about the dominant stereotypical views of binary genders which although present as functional for many, they are not absolute and therefore can pose great difficulties for others. To understand the impact of CSA on men's identification with masculine roles, it is necessary to examine the meaning of masculinity from different perspectives.

Although there are certain characteristics shaped by the Western society which are linked to the dominant concept of masculinity, such as leadership, assertiveness, independence, aggression, violence, preoccupation with sex, avoidance of emotions and expression of vulnerability (Kia-Keating, Grossman, Sorsoli, & Epstein 2005), the psychology of men and masculinity literature agrees that there are several ways of enacting masculinity (Wade & Good, 2010). This notion is reflected in the social constructionist positions on masculinity which tend to hold the view that masculinities are not fixed. Men engage in the process of masculine socialisation which is understood as a process of expressing cultural values, norms and beliefs about masculinity (O'Neil, 1981). Men are in a continuous interaction with their social and cultural environments, endorsing different aspects of norms associated with masculine socialisation based on their age cohorts, race, ethnicity, culture, class and geographical regions (Wade & Good, 2010). This means that their masculinities are continuously constructed and challenged; thus, they may change across their lifespan (Addis & Cohane, 2005). From a social constructionist position the negative impact of the restrictions of the male gender role is captured through the theory of masculine gender conflict which refers to the negative consequences of adopting certain masculine ideologies. For instance, men's beliefs that they should be independent, self-reliant and tough could prevent them from seeking help when they are in need (Addis & Mahalik, 2003).

On the other hand, psychodynamic paradigms hold that childhood experiences are fundamental in shaping individuals' identity and play a pivotal role in their adult relationships (Fonagy & Target, 2003). Building on this principle, psychodynamic perspectives on masculinity generally agree that boys' interactions with their primary caregivers shape their identity which make these early relations critical in forming men's capacity to relate to others and be sensitive to their own and others' emotions (Addis & Cohane, 2005). Pollack (1998) theorises that men suffer from premature termination of their early holding environment due to pressures to disidentify with their primary caregivers (Pollack, 1998). The pressure to disidentify is characterised by Pollack (1998) as a normative developmental trauma linked to boys' gender. Krugman (1995), however, postulates that central to men's development and normative male socialisation is shame as the extreme avoidance of being shamed motivates boys to adopt male acceptable behaviours. The process of shame socialisation can be adaptive when boys learn to sensitise to different relations, e.g. with their intimate others, peers and authority. It can also become maladaptive when it is disrupted by trauma, developmental or gender-based pressures.

1.1.1 The challenges of the male gender role socialisation process.

Although these two paradigms are theoretically distinct, they both have informed research on masculinity and clinical practice of working with men over the past two decades. *The new psychology of men* (Levant, 1995) sees gender roles as psychologically and socially constructed. Drawing on this conceptualisation of masculinity, both paradigms will be utilised to examine and discuss the role of masculinity within the context of male CSA. Masculinity is not seen as a normative concept but as a complex construct with many unique interpersonal and psychosocial challenges which are considered to be the by-product of the male gender role

socialisation process (Good, Thomson, & Brathwaite, 2005). From an early age, boys are subjected to messages which shape their understanding of male gender behaviour, e.g. being told that “boys don’t cry, only girls cry”. This is a clear message that expressing emotions which indicate a sense of vulnerability and which allow others to see the impact of a difficult experience on them is unacceptable. Therefore, they learn that crying is only acceptable for females and if males cry, they are acting feminine. This leads boys to restrict and potentially repress emotions that could be associated with feeling vulnerable (Good et al., 2005). Research has shown that men are socialised towards resilience, physical aggressiveness, sexual subjugation, social status, emotional control and risk-taking (Mahalik et al., 2003). Going against the gender norm and engaging in alternative forms of expression leads to risking rejection, ridicule, humiliation and shame. However, it must be noted that despite these common trends in male gender role socialisation in the western world, significant variations are evident across time and cultures.

The social pressures of living up to the precepts of masculinity and conforming to masculine norms have with some exceptions (e.g. Good et al., 2005) been linked to negative effects on the health and wellbeing of males, e.g. substance abuse, anxiety and depression (O’Neil, 2008), higher risk-taking behaviours (Courtenay, 2000), higher rates of suicide and premature deaths (Möller-Leimkühler, 2003), as well as increase in negative health behaviours in men (Sloan, Conner, & Gough, 2015). The increasing awareness of the role that masculine identities play in the health and well-being of males provides a starting point for considering the issues that the development of masculine identities pose for male survivors of CSA.

1.1.2 Male gender role socialisation and the experiences specific to male CSA.

Male CSA survivors have been found to navigate within the expected lines of the traditional masculine roles with considerably more difficulty than men without CSA history (Kia-Keating et al., 2005). The effects of CSA can elicit incapacitating feelings of negative self-evaluation, profound shame, vulnerability and inability to express their emotions which have been suggested to change the course of the male survivors' self-identity development (Kia-Keating et al., 2005; Von Hohendorff et al., 2017). The experiences of sexual victimisation and the perceived expectations of adopting traditional male gender roles can be difficult to reconcile (Kia-Keating et al., 2005). Briers (2000) examined the impact of CSA on male gender identity and found that the experience of CSA not only impacted the survivors' ability to identify with traditionally held masculine values, but they also struggled to identify with 'positive' feminine attributes, e.g. emotional expression and interpersonal competencies. Consequently, males have been suggested to struggle to integrate their shame-based experiences which can lead to a male gender role strain (Pleck, 1981) and a trauma strain in CSA survivors (Lisak, 1995). Therefore, male socialisation is essentially said to be experienced as traumatic by many male CSA survivors (Levant, 1995).

Spiegel (2003) developed a model that aims to capture the dynamics of sexual abuse against male victims which also highlights the role of fear of social perception in the survivors' experiences. The model consists of seven phases: (1) subjection - the process of the perpetrator finding ways to get closer to the victim and gain their trust, (2) sexual abuse - episode/s of the act of abuse, (3) concealment - hiding of the abuse mainly through pressure from the perpetrator, (4) invalidation - victims deny the abuse happening, (5) reconciliation - acceptance of the abuse, (6) compensation - engagement in behaviours that are considered stereotypically masculine to

compensate for the contradiction experienced between the traditional masculine role and the victimising experiences of the abuse and (7) continuity - continuation of the cycle of abuse until the victim receives support/protection. Spiegel (2003) proposed that the wariness of stigmatising social perceptions that could lead to exclusion or further alienation from the masculine norm plays a significant part in the male victims' experiences of sexual abuse which are thought to differentiate the CSA dynamics between males and females. Although literature points to fear of being perceived as "damaged goods" in adult female CSA survivors (Henning, Walker-Williams & Fouché, 2018), weariness of stigmatising social perceptions and their consequences linked to fear of gender based alienation and subsequent compensation is not evidenced in female CSA dynamics models, such as Summit's (1983) accommodation syndrome model. In men, the fear of social stigmatisation is underscored by deeper issues of personal and social identity (McGuffey, 2008; Teram, Stalker, Hovey, Schachter, & Lasiuk, 2006). These findings are supported by Nicholls (2014) who explored male CSA survivors' help-seeking experiences and described men's dilemmas, challenges and complexities of accepting support due to stigma, social attitudes and gender issues specific to them.

Another factor that is proposed to have significance for males but not so much for females is the perpetrator's gender which is also linked to fear of social stigmatisation as it can contribute to how males are perceived socially. If the perpetrator is a female, the act may be seen as a "rite of passage" (Cashmore & Shackel, 2014). According to a prevalent belief, a sexual encounter between young males and older females is seen as an introduction to manhood, earning the approval and admiration of fellow males which can contribute to denial of the abuse (Coxell, King, Mezey, & Gordon, 1999). If the perpetrator is a male, this bears a great significance for boys due to the same sex-aspect of the experience. As the traditional norms of masculinity dictate avoidance of any attributes stereotypically perceived as homosexual (Doyle & Molix,

2014), the same-sex abuse can lead to uncertainty about the boys' gender identity and questioning of their sexual orientation. Moreover, due to the apparent physiological reaction during the abuse males may wish to justify the abuse to make sense of their reaction. Therefore, research suggests that most men do not label their CSA as abusive. In a sample of 323 men, only 49% of CSA victims and 24% of rape victims acknowledged their sexual victimising experiences (Artime et al., 2014).

The complexity of the male survivors' gendered issues with fear of societal judgement and the added pressure of being expected to bury or simply overcome their problems result in significant implications for the disclosure, help-seeking and after-effects of CSA (Easton, Saltzman, & Willis, 2014).

1.2 Disclosure of CSA in Male Survivors

In a study conducted by Priebe and Svedin (2008) from a sample of 4,339 female and male adolescents, 81% of females and 69% of males reported disclosure of CSA, with the majority disclosing to their peers. Very few of them disclosed to professionals (9% of the girls and 3% of the boys) or reported the sexual abuse to authorities (7% of the girls and 4% of the boys). Retrospective studies reviewed by Priebe and Svedin (2008) yielded a 31% – 41% disclosure rate in childhood and 58% – 72% disclosure rate in adulthood. Overall, there is a consistent trend across the literature suggesting that in most cases CSA is only disclosed in adulthood (Easton et al., 2014; Garnier & Collin-Vézina, 2016; Alaggia, Collin-Vézina, & Lateef, 2017) which points to the complex nature of the disclosure process.

McElvaney, Greene, and Hogan's (2012) theoretical model captures the disclosure process through three main dynamics: (1) active withholding - when young people do not want anyone finding out, they deny the abuse or only tell to a trusted few, (2)

pressure cooker effect - caught between wishing to tell and needing to withhold, (3) confiding - reflects the choice of confidante, context of confiding and need for confidentiality. The authors suggest that the disclosure is a dynamic, dialogical process that does not develop linearly. It may stop and start throughout the survivor's lifespan, influenced by multiple individual and environmental factors such as familial, contextual, social and cultural (Alaggia et al., 2017). Factors that have been found to act as facilitators can be internal (e.g. unbearableness of symptoms, awareness of CSA being an offense); circumstantial (e.g. eye-witness, evidence, filed report) and environmental (e.g. dialogical contexts that provide opportunities to engage about CSA, supportive settings, such as counselling, forums and workshops). While, Collin-Vézina, Sablonni, Palmer, and Milne (2015) identified three groups of barriers to disclosure: (1) barriers from within including self-blame, self-protection and immaturity, (2) barriers in relation to others, e.g. lack of support, unstable home environment and fear of the impact of disclosing, (3) barriers in relation to the social world, e.g. socio-cultural factors, stigmatisation and the taboo of the subject.

1.3 Men, help-seeking and therapy

Given the issues of masculinity, male gender role socialisation and its impact on men, consideration must be given to men entering an intimate relationship as is the therapeutic one. Addis and Mahalik (2003) proposed that the more men endorse traditional male gender roles, the less likely they are to seek help. Masculine socialisation towards independence, self-reliance and stoicism can leave men ashamed to seek help and avoidant of relationships that could place them in a vulnerable position (Addis & Mahalik, 2003). Sullivan, Camic and Brown (2014) found that men who appeared to demonstrate higher fears of intimacy, traditional masculine ideology and scored higher on normative alexithymia were more negative about help-seeking. Therefore, often when men present to therapy, they are motivated by

external factors, e.g. through encouragement or ultimatum from their close-ones or through court order (Brooks, 1998).

However, building a therapeutic relationship requires collaboration, care, level of vulnerability and openness about matters personal to the individual (Good et al., 2005), with empathy being one of the fundamental building blocks of establishing a therapeutic alliance and achieving a therapeutic change (Rogers, 1951). These elements of a therapeutic relationship are likely to evoke incongruent experiences between the way men have been socialised from an early age and the way they are expected to be in therapy (Brooks, 1998). Characteristics that are desirable for an effective therapeutic dynamic are often considered feminine; thus, endorsement of a traditional masculine expression could result in men avoiding feeling empathic or at least avoiding being seen as empathic. Research on gender differences into empathy indicates lower rates of empathy in men in comparison to women when the studies use self-report measures (Baez et al., 2017) indicating that when men are asked to report on their levels of empathy, they act in line with the expected male gender expression. O'Neil (1981) supports this by suggesting that as a result of male gender role socialisation, men learn to devalue empathy in themselves and in others. Research which suggest that the restrictive masculine expressions are barriers to help-seeking in men are challenged by another strand of research systemised in a scoping review by Seidler, Rice, Ogrodniczuk, Oliffe, and Dhillon (2018) which suggests that men are deterred from seeking help by service limitations, such as structural barriers, uninviting environments, clinicians' masculinity related biases and insufficient training.

The identified barriers to men's help-seeking behaviours have led to efforts to integrate recommendations to psychological treatment to men's specific needs (Been, Jeffries, Brownlow, Winterbotham, & Preez, 2017; Seidler et al., 2018). These

systematic literature reviews indicate the need to overcome men's ambivalence by working towards establishing trust, respect and understanding that can be maintained throughout the work even when some of the rigid masculine norms and associated feelings of anger and rage are being challenged. Seidler et al. (2018) proposed the following to deliver male oriented successful treatment: (1) focused and directed use of specific therapeutic techniques to establish a collaborative, therapeutic relationship (2) establishing a clear, goal- and action-oriented treatment structure (3) use of a jargon-free, direct and specific language, and (4) therapy practitioners to resolve their own gendered presumptions. Been et al. 's (2017) qualitative systematic review of research published between 1995 and 2016 on recommendations for male-friendly individual therapy identified four themes: (1) knowledge about men, masculinity and male gender role socialisation, (2) therapists' self-awareness, (3) tailoring treatment based on male gender role socialisation and (4) male gender role informed actions and goals. Although these studies demonstrate clear efforts to support men's help-seeking and engagement in psychological treatment, the recommendations seem focused around men who subscribe to male gender role socialisation but may not consider the needs of men who may not identify with traditional masculine norms and attributes. It is important that services and practitioners recognise the diversity of males' expressions and do not fall into a "one size fit all" approach as this may lead to reinforcing masculine stereotypes. This is supported by Briers (2000) who found that regardless of their sexual orientation male CSA survivors expressed ambivalence towards conventional gender roles. Subsequently, Briers (2000) suggested that the framework of conventional sexual and gender categorisations is likely to be of limited relevance in the work with male CSA survivors and called for development of models that are more in line with male CSA survivors' perceptions of gender and sexuality.

Tailoring therapy to men's needs may not only require consideration for the therapists' practices and self-reflective capacity but the potential influence the therapists' gender

have on male clients. Research (Clarkin & Levy, 2004; Owen, Joel, & Rodolfa, 2009) generally indicate that therapy outcomes do not vary based on clients' or therapists' gender; however, some studies indicate variations in findings. Wintersteen, Mensinger, & Diamond, (2005) found that gender matching only enhanced the therapeutic relationship and the therapeutic outcomes in some adolescents' cases but was found to have mediating effects when working with more than one person, i.e. couples or family therapy (e.g. Blow, Timm, & Cox, 2007). However, Owen et al. (2009) found that some therapists are better at treating men while others are better at treating women. Therefore, they provide evidence for gender competence and propose it to be directly linked to therapy outcomes. However, it remains unclear what makes some therapists more competent working with female clients and other therapists with male clients. Bhati's (2014) findings do not corroborate these outcomes as he discovered a general "female effect". Female therapists matched better with both female and male clients. The female therapists' therapeutic alliance throughout the different stages of therapy were reported higher than those of male therapists.

1.4 (Male) CSA Survivors' Experiences of Professional Support

Due to considerable lack of evidence about CSA survivors' support needs in the UK, Smith, Dogaru, and Ellis (2015) conducted a research based on one of the largest surveys ever carried out with 395 CSA survivors, with only 13% male representation. As the participants were recruited through support organisations, they all sought support at some point, but the average time between disclosure and service use was 12 years. The most common services sought were GP, police, statutory mental health services, voluntary counselling and rape support services. The survivors used on average 4-5 services, with the average time span being 10 years between the first and the most recent service used. On a 5-point Likert scale, the average satisfaction with all services was 2.5 (neither good nor poor). However, a clear pattern of statutory

services being rated as poor and voluntary services being rated as good became evident. Satisfaction with services was linked to survivors feeling listened to, believed and respected. Moreover, it was the counselling and psychotherapy cluster of services that the survivors found most satisfying. The identified barriers to help were poor service experience where service response was inconsistent, therapeutic response was inappropriate, professional approach was impersonal and over-reliance on pharmaceutical treatment was experienced. Over half of the respondents wanted more counselling and psychotherapy services. Long waiting lists, short support time and limited range of therapies were also found problematic. A key barrier to getting support was the difficulty of talking about their abusive experience, with 80% of the survivors not being asked about CSA history. Survivors also frequently experienced symptom treatment as opposed to addressing the underlying issue of CSA. This is a very important contribution to the evidence base on CSA in general. However, the limitation of this study is that the experiences of females and males were reported together, and the male survivors only represented 13% of the participants; therefore, the male survivors' experiences cannot be extracted from the findings. The importance of being listened to was also captured by Barber (2012) who interviewed 3 female CSA survivors and 13 mental health professionals with the aim of exploring the experiences and needs of CSA survivors in therapy. The professionals' ability to listen suggested to the survivors that the professionals were comfortable with their disclosures. However, the opposite was most characteristic of the survivors' experiences. This study's limitation is its very small sample size of CSA survivors which only composed of female survivors.

As part of the Centre for research on families and relationships, Nelson (2009) carried out a study on the care and support needs of male CSA survivors. The male survivors reported a wide range of frequently severe mental health issues as a consequence of their CSA. The survivors reported both positive and negative experiences with

health services. They found that practitioners failed to identify or address their history of CSA and their treatment experiences ranged from no intervention to being over-medicated and controlled. Those who developed addiction issues to cope with their experiences of CSA and presented to addiction services found that the practitioners failed to recognise and address their CSA history and only dealt with surface issues. The survivors appreciated the input of those mental health professionals who were empathic, respectful, patient and had a good understanding of abuse trauma instead of focusing on one type of therapy over another. In general, the male survivors found their experience of counselling positive and this was particularly the case for those receiving counselling in prison. Both studies (Smith et al., 2015; Nelson et al., 2009) indicated mixed service-related experiences, with the positives being appreciation of counselling support and respectful approach, and the negatives being avoidance of dealing with CSA related issues and over-reliance on medication.

The service restrictions captured in Nelson (2009)'s enquiry are symbolic of the shortage of services specialising in supporting males with childhood sexual abuse. Although there are a number of SA and CSA focused services such as One in Four in London, Survivors in Transition in Suffolk, Into the Light in London and Brighton, Sunderland Counselling Service as well as rape crisis centres spread across the UK, only a handful of male SA and CSA specialist services have been identified, such as Survivors UK in London, Mankind a Sussex based service, Survivors Manchester and Speak Out Scotland. Research (Teram et al., 2006) indicates that in addition to common fears and anxieties that female and male CSA survivors both experience when meeting healthcare professionals, they also report gender-based differences related to perceptions and expressions of vulnerability, abuse disclosure, victimhood, guilt and shame, and homophobia. For men these areas represent an additional difficulty in their encounter with health services, thus, reinforcing the need for more male CSA specialist services. In Teram (2006), the male CSA survivors reported

experiencing differential reactions from health-care professionals with their help-seeking. Health professionals were sceptical about the survivors' revelations of their CSA experience, treated their experiences as less severe or simply as sexual experimentation (Teram et al., 2006).

A smaller-scale study conducted by Rapsey, Campbell, Clearwater, and Patterson (2017) interviewed nine male survivors about their experiences of therapeutic support. They were all members of a support group for male SA survivors. They encountered number of obstacles of getting help; stigma, finding a skilled and empathic therapist, and process barriers. They described negative experiences with number of therapy practitioners before they were able to find one who they felt they could connect with. Some of them felt that the therapists did not understand their abusive experience and that deterred them from talking about it, and others experienced the professionals' avoidance to address the survivors' abusive experience despite them seeking help with the issue of CSA. Those that persevered and overcame the barriers, reported improved quality of life in terms of their relationships and changed thinking which they were able to achieve through a strong therapeutic relationship. They developed increased awareness of not being responsible for the abuse, understanding of the impact of the abuse on them and a separate identity from being abused. A possible limitation of this study was that these survivors were already part of a support group which would have provided some level of belonging, awareness of not being alone in being a male survivor and support to keep persevering in getting the right help. However, this may not be the case for many male survivors who therefore could be more easily deterred by their initial negative experiences of seeking treatment. A common theme among male CSA survivors' experiences of health professionals prevails in terms of challenges of finding skilled and empathic professionals who can address the issue of CSA with them and who will not reinforce the males' stigmatising experiences of seeking help.

With the male CSA survivors' gender-specific concerns about seeking and receiving therapeutic support raised in the previous studies, Moriarty (2017) provides a hopeful insight into the aspects of the therapeutic process that promote trust and building a therapeutic relationship with male CSA survivors. Moriarty (2017) interviewed six male clients with CSA history about trust and relational experiences in counselling. She found that connecting with and learning to trust the therapist was facilitated by the therapist having knowledge and experience of SA accompanied by non-judgemental attitude, understanding and equal power dynamics. Equal power dynamics were facilitated by the clients' ability to safely challenge their therapists which contributed to their feelings of empowerment. This was also an important part of a process of relationship with themselves and accepting of their own experiences which contributed to a greater faith in their own process and acceptance of their needs. Masculine gender identity and its exploration contributed greatly to the therapeutic relationship. However, it was important that this exploration was led by the clients and not the therapists. Finally, the clients learnt to trust their therapists through a reciprocal process of learning that the therapists were accepting and non-judgmental whilst the therapists were getting to know their clients. This set the right conditions for the clients being able to share the traumatic material with greater assurance.

1.5 Health Professionals' Attitudes Towards Working with Male Survivors of CSA

To date there is a lack of systematic enquiries into practitioners' work with male CSA survivors (Teram et al., 2006; Sivagurunathan, Orchard, & Evans, 2019; and Yarrow & Churchill, 2009) which is evident in the issues identified in the research available as is in the male survivors' experiences of treatment. The majority of the existing enquiries are into health professionals' attitudes, and only a negligible amount of

research has explored therapy practitioners' experiences of working with this client group, with much of the research published over two decades ago.

Similar findings to the ones reported by male CSA survivors were indicated by studies that explored therapists' attitudes towards working with male CSA survivors. A study conducted by Holmes and Offen (1996) found that UK-based clinical psychologists were significantly more likely to attribute symptoms presented in a case material to CSA abuse when they were told that the client was a female than when they were told the client was a male. The finding that clinical psychologists tend not to suspect sexual abuse in males indicates that their perceptions of males may be shaped by underlying societal preconceptions. This study had a low response rate and the psychologists' variables linked to postulating sexual abuse in their clients did not have the necessary power to generate many significant results. Nevertheless, comparable results were found in a US-based study (Richey-Suttles & Remere, 1997) exploring 154 psychologists' attitudes towards male SA survivors which found that the psychologists' attitudes towards men was a significant predictor of victim-blaming. Severity of the abuse, the psychologists' attitudes towards men, their experience of treating sexually abused men and the response of the victim were predictors of the psychologists interpreting the incidents in the vignette as sexually abusive. Limitations to the study were lack of generalisability and limitedness of the research instruments due to low reliability (Richey-Suttles & Remere, 1997). Nonetheless, this study indicates that several factors may affect psychologists' attitudes towards male survivors of CSA, many of which can be linked to societal influences and biases.

Both studies (Holmes & Offen, 1996; Richey-Suttles & Remere, 1997) postulate that the societal narrative of the traditional masculine role is also ingrained in psychologists' perceptions and attitudes which in turn may impact their professional conduct. A literature review by Holmes, Offen, and Waller (1997) found support for

these findings, indicating that clinicians are reluctant to suspect the history of CSA in males and as a result they are less likely to enquire about it. Moreover, when a history of CSA is disclosed by men, clinicians are less likely to believe it or consider it a problem requiring therapeutic input. Although the findings are from two decades ago, they suggest similar outcomes to Gruenfeld, Willis, and Easton (2017) where nine mental health therapists specialising in the treatment of men who were sexually abused in childhood felt that many therapists who have previously not worked with male survivors are prone to believing in gender norms and hold the view that women are victims and men are perpetrators.

A UK-based study surveyed mental health professionals' (psychologists, psychiatrists and nurses) attitudes and practices towards male CSA (Lab et al., 2000) and found that most of the professionals seldom ask male clients about their history of CSA. Only 2.5% of psychologists ask their patients about CSA always and 50% of them never do. The most common answers given by all professionals as to why should one not ask about the history of CSA were: (1) it can be too invasive and affect engagement, and (2) it is too inappropriate if patients' presentation is not relevant to sexual abuse, such as phobias and psychosis. Less frequent answers included worries of patients becoming aggressive and angry, discomfort around asking the question, more burning issues to deal with, not wanting to worsen the patients' condition or the patients being actively psychotic. This study used self-report questionnaires which carry the risk of the participants' answers not reflecting genuine responses but a desire to provide answers perceived more favourably and they restrict the participants from providing in-depth answers. Despite these limitations, a study carried out by Young, Read, Barker-Collo, and Harrison (2001) reported similar findings where 63 psychologists and 51 psychiatrists were reluctant to enquire about abuse histories due to dealing with more urgent issues, being afraid of disturbing their clients and contributing to their deterioration. Besides, some of the professionals

feared inciting “false memories” in their clients. The professionals were less likely to ask about abusive histories in cases in which they believed that their clients disclosed false memories. Professionals' caution around inducing “false memories” is likely due to frequent media allegations of mental health professionals’ approaches of enquiry leading to the planting of “false memories” (Read, Hammersley, & Rudegeair, 2007). As discussed in Polusny and Follette (1996), this is the result of a divided debate within the psychological community on the validity of adults’ retrospective reports of CSA with some believing in the importance of addressing abusive memories already available to their clients and others arguing against therapeutic techniques leading to creation of “false memories” and devastating effects on clients and their families. This study (Young et al., 2001) also utilised a self-report measure.

The above findings provide evidence for health professionals’ attitudes towards males being affected by commonly held societal beliefs about men. However, it has also transpired that health professionals’ preconceived ideas may be mitigated by relevant experience, knowledge and specialist male CSA training as found in Richey-Suttles and Remere (1997). Psychologists’ experiences of treating sexually abused men predicted their interpretation of the vignettes describing sexual abuse of males. Lab et al. (2000) who found that psychologists seldom asked males about CSA history also reported that over 46% of the psychologists claimed to have received specific training in the area of sexual abuse. However, only 25.6% felt that the training was sufficient to allow them to enquire about CSA histories in male patients. It is interesting to note that the mental health professionals in this study did not believe that phobias and psychosis could be linked to a history of CSA as research clearly shows a high prevalence of childhood traumatic events including sexual abuse in patients with psychotic presentations (e.g. Bonoldi et al., 2013).

Holmes et al. (1997) also proposed that their findings could be the result of the professionals feeling insufficiently trained and knowledgeable. Kassing and Priero (2003) are in support of this as in their study counsellors in training without prior experience of working with male rape victims were more likely to agree with and follow societal rape myths of males. Paul and Paul's (2014) more recent US-based study corroborated these findings. They surveyed 41 counsellors about their attitudes of working effectively with sexually abused men. Counsellors believed that male-specific SA training and direct therapeutic experience with this client group were associated with effective practices with males with CSA history. They also held that awareness of personal SA history and counsellors being males also affected good practices with this client group. This study lacked racial and sexual diversity; therefore, the findings may not be representative of all practitioners' experiences. Holmes and Offen (1996) also found that more recently qualified clinicians who covered the subject of CSA in their training were more likely to suspect CSA in clients as opposed to those who trained earlier without being taught about CSA. Even though these findings were only significant for female clients, they suggest that increasing knowledge about CSA can lead to greater awareness of the possibility of CSA being the antecedent of clients' presenting difficulties. Day et al. (2003) also found that lack of CSA specific training can negatively affect mental health professionals' (nurses, psychiatrists, occupational therapists, counsellors, psychologists, social workers, art therapists and physiotherapists) self-reported experiences of not feeling comfortable and competent working with clients with CSA history. This study did not compare the findings between different professionals, nor did it differentiate between female and male clients. Considering the heterogeneity of the sample from more than eight professional disciplines, the nature and the extent of professionals' work with CSA clients would vary significantly as would the nature and the extent of their training needs. This makes drawing conclusions difficult.

Similar findings were identified when service provision for male CSA survivors was examined across eleven mental-health services in a US-based study (Sivagurunathan et al., 2019). Semi-structured interviews were utilised to explore service providers' views on the gaps in service provision for male survivors of CSA. They identified four themes: (1) limited services for this client group, (2) organisational policies and procedures that impede survivors' ability to access services, (3) dismissive behaviours, perceptions and attitudes of service providers deterring male survivors from seeking help and (4) inadequate male CSA education opportunities. Although these findings are specific to the service provision in a particular area in the US, they are indicative of the attitudes and education opportunities identified in UK-based studies; thus, suggesting an international trend related to the perspectives on the subject of male CSA.

To the researcher's knowledge, the only UK-based enquiry into therapy practitioners' experience of working with male survivors of sexual trauma was a pilot study carried out by Yarrow and Churchill (2009). The researchers conducted an IPA on data gathered through postal questionnaires completed by 32 counsellors and psychologists working for an NHS Trust department. Their aim was to increase awareness of the therapeutic needs of male survivors of CSA through exploration of therapy practitioners' experiences of working with them. They identified six main themes: (1) the therapists' gender was considered important as just under 90% of the participants felt that it had an influence on the client group (2) the therapists expressed professional concerns, including the ability to engage competently with their clients (e.g. not feeling experienced enough or able to help their clients), apprehension about their own vulnerability (e.g. arousing anger in their clients, questioning being the right therapist for the client), concerns about the counselling relationship (e.g. pacing the work, being mindful of boundaries) and attributing great significance to receiving supervision support with this particular client group (e.g.

therapists organising additional support for themselves) (3) considered the importance of a therapeutic relationship including creating a safe place, establishing trust and maintaining boundaries, (4) transference/countertransference including the importance of not being seen as the abuser, (5) 25% of the therapists saw no difference between this and other client groups and (6) awareness of clients' presenting problems, many of which were linked to the male gender role. This study provides a valuable initial contribution into increasing awareness of this subject area, while being limited in its use of questionnaires; thus, restricted in their depth of enquiry (Yarrow & Churchill, 2009).

Considering mental health practitioners' attitudes, aptitude and concerns working with male survivors of CSA also clearly captured in Yarrow and Churchill's (2009) study, it is surprising that no published studies have been found to explore therapists' affective reactions working with male survivors of CSA. The present literature review was only able to identify one published study (Knight, 1997) which did not differentiate between working with female and male survivors of CSA and as only 11% of the therapists worked with male survivors, the majority of the findings would have related to female survivors. Additionally, it was an exploratory study using a quantitative research design limiting the depth of its findings. The authors examined 171 therapists' affective reactions and the factors influencing their reactions. Contrary to previous findings, great majority of the therapists received specialist training in preparation for CSA work and the majority reported to have found it helpful. The therapists' most common responses were feeling overwhelmed by the work and experiencing a sense of vulnerability in personal relationships. The therapists' professional experience was found to be linked to their experience of feeling overwhelmed. The less experienced they were, the more likely they reported feeling overwhelmed. The therapists also reported feeling sadness and anger about their clients' experiences, horror regarding their victimisation and preoccupation with

thoughts of their clients outside their sessions, including rescue fantasies. Moreover, according to the author, their findings indicated that the severity of the clients' trauma may be felt by the therapists; thus, emphasising the role of survivors' symptoms and abuse characteristics in influencing therapists' reactions. It was also found that none of the therapists-related characteristics, their workplace or workload influenced their affective reactions. Instead, they were linked to the survivors' abusive experiences. What was not clear from this study was whether the therapists' affective reactions impacted their work. The therapists' affective reactions identified in this study appear consistent with experiences often described in trauma work.

In addition to Knight (1997), two unpublished doctoral dissertations were identified which examined trainee counselling psychologists' internal experiences of working with adult CSA survivors (Gilmour, 2015) and mental health counsellors' meaning making of working with adult survivors of CSA (Viviani, 2011). These studies used qualitative methodological approaches but similarly to Knight (1997), the researchers did not distinguish between work with female and male CSA survivors. In Gilmour (2015), the trainee counselling psychologists recognised the importance of balancing the power dynamic in the therapeutic relationship and emphasised creation of a safe therapeutic environment. Focus on management of vicarious emotional self-states was also identified as part of the work with CSA survivors. Finally, the complexity of the CSA work led the trainee counselling psychologists to question their professional competencies. The only gender specific finding was related to a male trainee feeling vulnerable to being perceived as an abuser when working with female CSA survivors and a female trainee expressing a level of discomfort over asking male CSA survivors about their arousal during their abusive experience. The researcher recognised having only one male therapist in her sample as a limitation and his experiences highlighting a need for further research. Viviani (2011) found that her participants who had over 20 years of experience working with CSA, were profoundly impacted by their

clients' stories which led them to identify ways of learning to cope with the stories without becoming traumatised by them. Some found support in their firm personal or professional foundations; strong belief systems and theoretical foundations assisted in their meaning making process. Others found comfort in having healthy personal relationships and quality personal times as well as reflective practice, monitoring for countertransference, supervision and mentoring which helped them to become aware of unresolved feelings. Above all, the participants found that establishing a therapeutic relationship was key to working with this client group. They found that they have grown over the years of practicing, developed new levels of empathy towards others and deepened the meaning in their personal relationships.

1.6 Vicarious Traumatisation

It is well known among clinicians and researchers that trauma work can be very demanding and have considerable emotional and psychological effects on therapists (Hesse, 2002). Therapists who work with trauma survivors, especially adult survivors of CSA, face particular challenges linked to personal and social meanings of interpersonal violence against the most vulnerable. They get exposed to their clients' explicit accounts of their CSA experiences and the realities of others' intentional cruelty and perpetration of violence against them. Their clients have experienced betrayal, boundary violation, broken trust and abuse of power, all of which they re-enact in the therapy room through powerful transference and countertransference exchanges with their therapists (Pearlman & Saaktitne, 1995).

The complex relational dynamics that surround CSA work (Etherington, 2000) are intertwined with managing clients' disclosures which are often experienced as challenging, disconcerting and helpless (Chouliara, Karatzias, Scott-Brien, MacDonald, MacArhur, & Frazer, 2011). Some therapists do not feel able to support

their clients adequately with their disclosure; therefore, avoid working beyond their clients' presenting problems stemming from their experiences of CSA (Orr, 1999).

The difficulty of listening to CSA survivors' stories has also been noted within the research field (Etherington, 2000), with others withdrawing from the subject of CSA and terminating conversations. Etherington (2000) explained these reactions as a natural response to subjects that are prohibited by social or cultural customs or norms. However, therapists not being open to hearing about survivors' stories and the general population not being ready to engage in conversations about CSA can effectively lead to the realities of these traumas being denied. Subsequently, denial of the traumas can lead to repetition of the psychological trauma of the survivors' primary abuse. Similarly, if therapists are ill-prepared to respond to survivors' disclosures competently or they do not feel adequately supported in their work, they are more likely to experience adverse effects of their work on their wellbeing. Etherington recognised that being exposed to the abusive stories and not having an appropriate outlet for them left her feeling isolated, alienated and powerless (Etherington, 2000) which can increase the risk of secondary traumatic stress (Perry, 2004).

The terms secondary trauma (ST), secondary traumatic stress (STS) or vicarious trauma (VT) are being used interchangeably across the literature. VT refers to the direct consequences of long-term exposure to others' traumatic experiences (McCann & Pearlman, 1990). The consequences are negative impact on the individual's cognitive, psychological and physical wellbeing; particularly disruption in a person's identity, sense of meaning and world view, disruption in affect tolerance, psychological needs, beliefs about self and others, interpersonal relationships and sensory memory (Pearlman & Saakvitne, 1996). It is suggested that the individual

develops the same symptoms as the person who had experienced the trauma directly (Perry, 2014).

Sui and Padmanabhanunni (2016) carried out a thematic analysis on 6 psychologists' interviews about the psychological impact of working with trauma survivors (mostly interpersonal trauma: physical and sexual abuse). All psychologists reported symptoms of vicarious trauma, including PTSD symptoms, disruption to cognitive schemas and somatic symptoms. However, they also found that the trauma work led to post-traumatic growth, including greater sense of interpersonal connectedness, and positive transformation of their self-perceptions and perspective on life. Nen et al. (2011) examined VT in professionals (police officers, social workers, medical social workers and counsellors) working with child SA cases in Malaysia. They found that all professionals regardless of their field of work reported feeling emotionally impacted by listening to the horrific stories of CSA and demonstrated symptoms of VT. The researchers identified ten themes: shock and disbelief, fear for oneself and children's safety, becoming overprotective, preoccupied with CSA stories, distrust of others, increased irritability, flashbacks, sleep disturbance and hyper-vigilance.

A literature review carried out by Chouliara, Hutchison, and Karatzias (2009) highlights the high prevalence of VT in therapists working with adult survivors of SA and CSA but without VT being found higher in those working with adult CSA survivors in comparison to professionals working with non-sexual abuse cases. These findings should be considered with caution as the authors discussed many methodological limitations of the studies under review which compromised the reliability of the results. A study conducted by Schauben and Frazier (1995) examined the effects of working with sexual violence survivors on female therapists (psychologists counsellors) with 87% of the survivors being female and 81% being abused in childhood. Therapists with higher caseload of SA survivors reported higher levels of PTSD, VT symptoms

and disrupted beliefs mainly about others' goodness. The participants reported the work with survivors being difficult due to the nature of the abuse itself and its consequences such as establishing trust. Many of the participants considered the most difficult aspect of therapy being dealing with the inefficient and unjust approaches of other systems, including the injustice of the legal system, inadequate funding for counselling and societal apathy about violence against women. Despite the challenging nature of the work; similarly to the findings of Sui and Padmanabhanunni's (2016); the participants in this study found the work rewarding. This was attributed to witnessing the clients grow and change despite their trauma; experiencing the clients as resilient, strong and creative in the work; attributing great importance to the work; being part of the healing process and recognising their own growth as therapists.

The effects of higher sexual abuse caseload on the therapists reported in Schauben and Frazier (1995) are in contrast with the findings of Chouliara et al. (2009) which could perhaps be attributed to the therapists' being all female. However, VanDeusen and Way (2006) who examined VT effects in male and female clinicians working with SA survivors and sexual offenders contest Schauben and Frazier (1995)'s findings. They examined the links between the clinicians' demographics, maltreatment history, their client population, and their cognitions about trust and intimacy with others. The self-reported disruptions in cognitions in terms of their intimacy with others surpassed norms for mental health professionals. Additionally, despite high report rates of childhood maltreatment, the researchers did not find a correlation between clinicians' history of CSA and VT.

According to Harris (1995), trauma workers undergo different stages of attempting to manage the effects of engaging with traumatic material constructively. In stage one, the therapist confronts feelings of secondary traumatic stress (STS) and tries to cope

with the psychological responses after exposure to traumatic material. The second stage is considered the stage of safety, when the therapist may or may not experience STS over a more extended time comparable to the development of PTSD. The third stage is considered the secondary traumatic stress response (STSR) stage during which the therapist attempts to integrate the experience into her or his cognitive model of the world. In the fourth stage, either the therapist has succeeded in assimilating the trauma effects, or he or she develops secondary traumatic stress disorder (STSD), hence resigning to a victim role. Harris (1995) suggests that during this time the therapist may appear as if he continues to try to integrate the effects of the trauma, but he or she is only attempting to reduce the effects of victimization. The existing literature indicates that there are certain factors that increase the risk of vicarious trauma in professionals and others that mitigate this risk. A meta-analysis of 38 publications by Hensel, Ruiz, Finney and Dewa (2015) examined 17 risk factors of STS among professionals working with trauma survivors and they found a small significant effect size for the volume of trauma caseload, frequency and ratio of trauma work as well as having history of trauma. While work and social support reduced the risk of vicarious trauma.

The increasing awareness of the adverse effects of VT and the risks of it developing in therapists have led to the literature on VT grow steadily. However, the current literature review was unable to identify studies that examined VT in therapists working with male survivors of CSA. Individual studies (Nen et al., 2011), including comprehensive literature reviews (Chouliara et al., 2009), explored therapists/clinicians VT in working with survivors of SA or CSA in general, as opposed to studies focusing either on work with male or female CSA survivors or comparative studies. Therefore, it remains unclear whether working with male CSA survivors has different impact on the therapists to working with female CSA survivors.

1.7 Summary and Limitations of Existing Research

Despite considerable advancements in the area of male CSA in the last three decades, the research remains relatively limited (Sivagurunathan et al., 2019). Exploration of male CSA survivors' experiences (Alaggia & Millington, 2008) and barriers to CSA disclosure (Alaggia et al., 2017) resulted in consistent findings about gender-specific CSA experiences (Alaggia et al., 2017; Kia-Keating et al., 2005) which have been linked to male socialisation (Rapsey et al., 2017). The traditional perceptions of masculinity and CSA being associated with female victimisation by male perpetrators (Andersen, 2011) have contributed to the socio-cultural denial of boys' susceptibility to CSA which pose significant barriers to men's acknowledgement of their abusive experience (Artime et al., 2014), help-seeking (Teram et al., 2006) and engagement in therapy (Rapsey et al., 2017).

The present literature review highlighted scarcity of publications exploring therapists' work with male CSA survivors. Some attention has been given to mental health professionals' attitudes towards working with male CSA survivors which have reflected societal preconceptions in professionals' attitudes towards their male clients. These findings were associated with lack of awareness and knowledge of male CSA issues and absence of male CSA specific training which appear to impact practitioners' confidence working with male CSA survivors and their abusive experiences.

In addition, the existing literature presents with a number of limitations. Much of the research used self-report measures which restrict the participants' ability to provide comprehensive in-depth accounts of their experiences. Some of the research recruited participants from several disciplines or omitted to differentiate between the CSA survivors' genders. Consequently, the heterogeneity of the samples makes drawing conclusions problematic. Moreover, due to scarcity of literature on work with

male CSA survivors, the current review included research from two decades ago. Although more recent studies confirmed trends identified in the older studies, caution should be exercised when approaching these findings. Research into male survivors' experiences of accessing treatment reflects some efforts towards development of male sensitive treatment; however, the existing recommendations appear to demonstrate lack of consideration for males who may not conform to traditional gender norms. Finally, the literature review could only identify one study which was a UK-based pilot study examining practitioners' experiences of working with male sexual trauma survivors. However, this study also used questionnaires for its data collection; thus, potentially limiting the depth of its findings.

1.8 Rationale, Aims and Objectives of the Current Research

Despite increased awareness of the prevalence of male CSA and growing understanding of the issue of male CSA, the literature remains surprisingly latent. Yet, the implications for both the survivors and those working with them are potentially significant. Research suggests that being a male is seen as a barrier to seeking help (Yousaf, Popat, & Hunter, 2015) Moreover, a history of CSA in men can pose an additional obstacle not only to help-seeking (Garnier & Collin-Vézina, 2016) but also to receiving support (Rapsey et al., 2017). Additionally, the complex nature of male CSA and the practitioners' ill-preparedness to work with it could result in secondary traumatisation (Pearlman & Saaktitne, 1995) of the practitioners and lasting negative effects on their professional practice and personal lives. Lack of information and expertise about how to address the male survivors' needs in terms of policy, practice and interventions across their lifespan can result in perpetuation of the myths of male CSA, lack of attention towards prevention and prolonged suffering of the male survivors.

Male survivors' input about their experiences of CSA is one form of enquiry which can inform the development of the best line of support for male CSA survivors. Although the research into male CSA remains limited, the advancements made so far have mostly been achieved through exploration of male survivors' experiences. The range of unique, long-term adverse effects of CSA (O'Leary et al., 2017) and the identified need of specialist support (Teram et al., 2006) suggests that therapy practitioners' input could also be of great value in enhancing our understanding of the male CSA survivors' needs. No existing research have been found to employ in-depth methods of enquiry into therapists' experiences of working with male CSA survivors; therefore, the use of semi-structured interviews is considered appropriate in gaining greater insights into the subject matter. This can provide the much-needed understanding of how best to support the male CSA survivors and their therapists' practices which can have implications for future research advancements, service provision, training and policy making.

1.9 Research Questions

In accordance with the research aims and objectives, and to enhance understanding and knowledge of this under-researched area, the following research questions have been formulated:

- How do therapists experience work with male survivors of CSA?

- How do therapists make sense of their experiences of working with male survivors of CSA?

It is important to note that this research does not intend to disregard women's experiences of CSA or therapists' work with female survivors of CSA. However, due

to the comparatively limited attention given to the subject of male CSA, the focus for the current study concerns therapy practitioners' experiences of male survivors of CSA.

The next chapter outlines the methodological approach and the research methods applied to answer the above research questions.

Chapter 2 – Methodology and Methods

2.1 Methodology

The research questions address individuals' lived experience and the meaning-making of their experience as this study endeavours to understand the therapists' experience working with male survivors of CSA and how they make sense of their experience. Therefore, a method that highlights phenomenological enquiry and focuses on exploring a phenomenon from the individual's perspective was chosen. This approach is consistent with the aims of counselling psychology which concentrate on the individual within a particular context, acknowledging the individual's unique, subjective experience with due respect to his values and beliefs, and where he is considered to be the expert of his experience. Therefore, counselling psychology recognises the socio-cultural context the individual is situated in and aims to empower the individual as opposed to supporting him from a position of power.

This chapter details the rationale for choosing qualitative methodology. This is followed by the methodological and philosophical considerations that aided in choosing a research paradigm best suited to address the research questions. It then details the rationale for choosing IPA and describes the epistemological and ontological positions in doing IPA. Subsequently, it describes the philosophical

underpinnings of IPA and its link to the field of counselling psychology. It discusses the consideration of other qualitative methodologies before it moves onto describing the procedures, ethics and the process of transcription and analysis of the data. Finally, it discusses how quality is assessed in qualitative research and how this is reflected in IPA and particularly in this research.

2.1.1 Rationale for qualitative methodology.

The choice of a particular methodological approach should be guided by a number of considerations. It is imperative to ensure that the research methodology is appropriate to the research aims. The research aims and objectives of the present study reflect an interest in gaining a greater understanding and a deeper appreciation of the subjective experience of a small sample of individuals without prior determination or hypothesising generated by existing theories (Willig, 2013). It is also important to ascertain that the study the researcher sets out to do is not a direct replication of an existing research without the potential for further contribution. The majority of the literature reviewed in chapter One that explored mental health professionals' and therapy practitioners' attitudes towards working with male CSA clients used vignettes, surveys or questionnaires. Importantly, only one study which was UK-based explored therapists' experiences of working with male survivors of CSA which also utilised postal questionnaires as their method of enquiry, thus limiting exploration of the therapists' experiences. Therefore, the present study will use a qualitative methodology which will allow for an in-depth enquiry of a complex phenomenon that has received little attention.

2.1.2 Methodological and philosophical considerations.

Choosing a research paradigm requires some considerations. Some of these are practical like the researcher's interests and previous research carried out in that area

and others are guided by the researcher's philosophical stance in terms of her assumptions about reality. The chosen perspective is contextual constructionism (Jaeger & Rosnow, 1988) which lies on an epistemological and ontological continuum between naïve realism at one end and radical constructionism at the other end. To provide a clear rationale for the chosen perspective, the opposite ends of the epistemological range and their unsuitability for this research are discussed first. This is followed by discussing three alternative epistemological positions located in-between the opposite ends of the continuum that were considered at the start of the research process. Finally, the attention will be focused on describing the epistemological position concerning the chosen methodology and clearly outlining the researcher's rationale for both.

Naïve Realism holds that truth about the world is essentially identifiable since it is perceived through the senses largely as it is (Madill, Jordan, & Shirley, 2000). It assumes objectivism and dualism. In other words, it considers reality to be constant and therefore independent of human observation or interaction. Researchers who adopt naïve realism believe that their topic can be measured objectively without researcher bias and any potential influence that the researcher and the participant may have on one another should be avoided as it could invalidate the research outcome (Ponterotto, 2005). Approaching the research from a naïve realist position would mean believing that there is an absolute truth, a reality to be identified which is knowable through observation. The participants' experiences of working with male survivors of CSA would not be dependent on their ability to share their experiences with the researcher or on her ability to understand the information communicated to her or the circumstances of the interview process. It would be a fact that would be knowable to the participants and to the researcher.

At the opposite end of the continuum sits radical constructionism. It declares a relativistic position assuming multiple, equally plausible realities. It proposes that there is no ultimate basis for knowledge. It acknowledges the world and other people, but it holds that the way they are perceived are merely the results of individuals' construction. We are never capable of knowing the truth or reality about the world (Raskin, 2002). According to Von Glaserfeld (1995a), we are only able to know if our construction of reality fails, but we have no access to knowing the world in an objective manner. Radical constructionists attribute great importance to language as it enables individuals to communicate with each other; thus, it supports the maintenance of social realities. However, they also hold that communication is imperfect, and we are unable to provide each other with our held meanings through communication (Raskin, 2002). Therefore, we stay isolated in our constructions of the world. On that basis, the participants could only communicate to the researcher their individual constructions of their reality of working with male survivors of CSA and the meanings that would be communicated to the researcher would not be accessible to her. She would only have access to her own construction of the information shared with her.

Neither of these positions are suitable to answer the research questions of the present study which focus on the therapists' experiences and meaning-making process of working with male survivors of CSA. This research is not interested in accessing an ultimate reality, nor does it pose an idea of inaccessibility of the phenomenon under research. The present research is interested in gaining insight into the therapists' world of working with male survivors of CSA. It is keen to get closer to what this experience is like for the therapists and how they create meaning from their experiences. The researcher believes that she cannot gain full access to the therapists' experiences, but she can get closer to them by engaging in a deep enquiry about their experiences. She also believes that the therapists' accounts are subject

to the dynamics and the circumstances of the enquiry. The product or creation of this joint meeting will not expect to reflect objective truths independent of the therapists' or researchers' interpretation, nor are they believed to be simple representations of discursive constructions of reality.

Although neither of the far ends of the epistemological continuum have been deemed appropriate for approaching the research questions of this study, the researcher gave careful consideration to three epistemological positions situated in between the polar ends which are perhaps closest to each other in their answers to the question about the degree to which our understanding of the world can attain some kind of knowledge about the world. These are the scientific realist, critical realist and contextual constructionist epistemological positions which are frequently adopted in qualitative research that focus on exploration of a phenomenon.

From a scientific realist perspective, the current study would aim to find ways of accessing the therapists' true feelings and experiences about working with male survivors of CSA. The researcher's focus and challenge in this case would be to find the best form of data collection that would allow the therapists to express themselves as openly as possible in order to get access to the therapists' real experiences. Adopting a critical realist position, the researcher would also aim to get a glimpse of the therapists' real experience but with the acknowledgment that the route to accessing this knowledge can be influenced by the researcher's observation which is at least partially shaped by her expectations and believes. This position combines the realist's aspiration to obtain some access to what 'really' is with the relativist's recognition that access to the knowable is subject to the researcher's interpretation of the observable (Willig, 2008). The contextual constructivist position goes a step further towards the relativist end of the epistemological spectrum by holding that whilst someone's experience is 'real' to them, this experience is always created within

a certain context and shaped by the individual's perception of that context. Therefore, it asserts that a pure or real experience independent of its surroundings does not exist. The researcher's attempt to understand the individual's experience introduces further contextual layers to the process of understanding of the phenomenon which would only allow the researcher access to her interpretation of the phenomenon under investigation.

This qualitative research aimed to explore therapists' experiences of working with male CSA survivors. The researcher considers CSA to be an event which is something that happens in certain place during a particular interval of time; therefore, from the researcher's point of view the occurrence of the physicality of this event is indisputable. However, this research is not interested in the physical foundations of the event that can be understood using merely objective terms. The researcher is interested in the therapists' unique, subjective experience of working with those male clients who experienced the physical eventuality of CSA along with the mental interpretations of the physical event which the researcher believes to be context dependent. The researcher holds that the therapists' experiences would have been shaped by multitude of factors and that their experience is not complete and fixed but rather continues to be subject to ever evolving and changing contexts. Therefore, the researcher believes that the therapists' description of their experiences would also be influenced and shaped by the interview process and the therapists' experience captured in the research project is merely the researcher's interpretation of the therapists' described experience which is subject to the context it is captured in.

With this in mind, the researcher positioned her research and herself within it, not from a realist epistemological framework but within a contextualist constructionist stance, exploring the therapists' experiences of working with male CSA survivors

viewed as circumstance and context dependent constructions unique to each individual.

By positioning herself within the contextualist constructionist stance, the researcher rejects the prospect of reality, any access to it and the idea of the objectivity of research process. For these reasons, constructionists are often criticised for what is often viewed as an inability to assert anything about anything (Stam, 2001). However, Stiles (1993) proposed that objectivity when approached from a constructionist perspective can be interchanged for permeability, the ability of understandings or interpretations to be altered through encounters with observations. The contextualist constructionist stance focuses on the subjectivity of experience which forms part of the context of exploration and investigation. The individual and his experience is constitutive of their social world and he develops meaning through engagement with it (Eatough & Smith, 2017). Stiles (1993) further proposed that mindful engagement with the researcher's subjectivity can enlighten the context of the researcher's interpretations and may exemplify a meaningful source of information. In fact, contextual constructionist position considers these influences to be essential contributing factors to uncovering meaning. Commonalities between participants and researchers, such as sharing personal views on subjects or having similar cultural understandings, can help create a connection between the researcher and the participant and can lead to a closer understanding of the participant's lived experience (Madill et al., 2000).

The basic contextualist supposition is that humans play an active, intentional part in the ever-changing reality of an always-evolving world. Human intentionality manifests within the context of relationships and meanings which are embedded in an altering historical and socio-cultural environment. These active, changing events are central in the researcher's quest for knowledge, and they provide the basic principles of the

contextualist stance. These events are concrete, placed in certain time, and they unfold in relation to specific factors and circumstances that shape them at the same time. As the context constitutes the concrete event, the event would not exist the way it does without the context it unfolds in. The context can change the meaning of the event as the alterations in the event can initiate changes in its context which means that the context and the event are interdependent (Jaeger & Rosnow, 1988).

From a contextualist constructionist position, the thus far described change is not an aspect of the determined order of the world as naïve realism would understand it. Reality is ever-changing and in constant process of forming and making. Order and disorder are manifestations of the changing reality. Contextualist constructionism holds that absolute truth is indeterminable. Knowledge of the world is relative and incomplete. Contextualist constructionism recognises that perception of the senses is subject to the mental apparatus that establishes the individual's impressions of her or his senses within a certain context (Hamilton, 1994). Therefore, humans can only possibly have access to their interpretation of reality that is not stagnant but ever-changing and determined by the context it becomes realised in (Jaeger & Rosnow, 1988).

2.1.3 Rationale for choosing IPA and my epistemological position.

I chose interpretative phenomenological analysis (IPA) to conduct my research as it focuses on a systematic exploration of the individual's perspective of her or his personal experience (Tomkins, 2017). It explores the person's lived experience and the sense he or she makes of her or his personal and social worlds (Smith, 2004). Therefore, it facilitates exploration of the research aim which is to learn about the therapists' individual experiences of working with males with CSA history through means of a purposeful conversation.

Using IPA as the chosen methodology, the researcher is seeking to gain an "insider's perspective" into the participants' experiences. IPA stands out amongst other qualitative methodologies by permitting a level of "epistemological openness" (Larkin, Watts, & Clifton, 2006). Thus, IPA's flexibility of approach on how the insider's perspective is explored, interpreted and understood (Smith, 1996) offers an opportunity to get closer to the individual's lifeworld provided that the researcher can skilfully and rigorously navigate her exploration of phenomena within the remits of the phenomenological and interpretative foundations of IPA.

The researcher approaches her research from a contextual constructionist position. She believes that the data is context-dependent and the interaction between the researcher and the participant can influence the participants' accounts. Contextualism recognises the contextual dependency of human activity as the individual not only constructs the context within which his activity unfolds, but he is also affected by the consequences of that context (Jaeger & Rosnow, 1988). This reflects IPA's understanding of our engagement with the world being mutually constitutive. Eatough and Smith (2017) take this further by quoting Merleau-Ponty (1945/2004, p. xii as cited in Eatough & Smith, 2017) "Man in the world, and only in the world does know himself." This quote highlights the tight and inextricable connection the person has with the world; thus, the person is only able to know himself in relation to the world. Consequently, each individual's connection to the world is unique in his experience of the world, and any change in the individual or his world will result in a different experience of the world. The researcher believes that the research data is the product of the therapists' experiences acquired within a certain context, such as their individual differences and sociocultural backgrounds, previous professional experience and life experience, as well as the product of the context within which they shared their experiences with the researcher, e.g. how

comfortable they felt in the interview session, their impressions of the researcher or their motivation to share their experience.

Similarly, the researcher holds a belief that the participants' accounts of their experiences can be interpreted in multiple ways through the influences of the researcher's socio-cultural and historical background. For instance, prior experience of working with male survivors of CSA or personal history of abuse, shared interest of the subject or an indiscriminate attitude can all influence the researcher's interpretation of the accounts of the therapists' experiences. Contextual constructionism recognises the inter-subjectivity of the participant-researcher quest for knowledge embedded in a socio-cultural and historical context (Jaeger & Rosnow, 1988). Therefore, it encourages the researcher to enunciate her position from which she approaches the subject of her enquiry. This can provide the reader with an understanding of the background the participant and the researcher may or may not share and can implicitly indicate its part in co-creating the findings (Jaeger & Rosnow, 1988). Furthermore, it can shed light on the researcher's biases that both contextual constructionism and IPA regard to be inevitable. Constructionist approaches resonate with IPA's view of the importance of the researcher engaging with her biases, assumptions and preconceptions in a productive manner with the objective being greater understanding (Ponterotto, 2005; Eatough & Smith, 2017). Accordingly, at a later stage, the researcher will talk about the similarities and the differences between the participants and her, and she shall reflect on the dynamics of the interview processes with her participants.

Constructionism emphasises the importance of the interaction between the participant and the researcher. It considers the interaction to be a joint, creative and active process that allows the co-creation of the findings within the context that it occurs in and it is shaped by (Ponterotto, 2005). This claim resonates with IPA's

position which suggests that the analytic process is always created by the participant and the researcher. Therefore, the form of enquiry (e.g. the interview process) in the search for knowledge needs to be carefully considered as it can not only facilitate the revelation of a deeper meaning, but it can also inhibit or block this process (Jaeger & Rosnow, 1988).

As typically with IPA, the researcher used semi-structured interviews to learn about the participants' experiences of working with male clients with a history of CSA. The research questions aimed for the participants to reflect on their experiences of working with male clients with a history of CSA and they intended to engage them in examining their meaning-making processes of working with this client group. The interview questions were developed in mind with the aims and objectives of the study; however, they simply served as a guide. The researcher's aim was for the conversations to unfold as naturally as they could to facilitate the exploration of the participants' experiences. Ponterotto (2005) emphasised the importance of the natural progression of the interview as it enhances the rapport between the researcher and the participants. Smith and Osborn (2003) referred to the participant being the "experiential expert", the one telling the story and not the respondent to interview questions. The interviewer is the facilitator who assists the expert in sharing his story; thus, helping him to bring the story to life.

2.1.4 The philosophical underpinnings of IPA.

IPA was developed by Jonathan Smith in the mid-1990s as an approach to qualitative research. His motivation was to have a research methodology that was rooted in psychology and which captured the experiential side of the psychological discipline (Smith, 1996). IPA is interested in the detailed exploration of individuals' subjective accounts of their experiences as they make sense of them. IPA does this by drawing on the theoretical foundations of phenomenology, hermeneutics and idiography.

Phenomenology is concerned with the individual's conscious subjective experience of certain phenomena (Smith et al., 2009). It aims to reveal meaning by concentrating on the individuals' stream of consciousness through their use of language and communication of their thoughts and emotions which brings the researcher closer to their internal world. IPA seeks to understand the meanings participants ascribe to their experiences. As it considers participants to be the experts of their own lived experience, it endeavours to get an insider look by creating a platform for them to share their stories and give detailed accounts of their experiences. IPA does this not only by focusing on the individuals' stories but also on the context they occur in influenced by social, cultural and historical factors (Eatough & Smith, 2017). According to Heidegger's version of phenomenology, it is impossible for the person not to be subjected to influences of language, history, culture and ideology (Rennie, 1999). Therefore, for the researcher to gain a close understanding of the participants' accounts of their experience, they must not only focus on recounting the participants' stories, but they must consider the stories within the context they were created (Noon, 2018).

Hermeneutics refers to an act of interpretation (Noon, 2018) and through interpretation it emphasises the meaning we attach to certain phenomena. Interpretation is a fundamental part of IPA. For the researcher to be able to make sense of the participant's experiences, she is required to engage in an interpretative process, which is two-fold and is referred to as double-hermeneutics. The researcher is attempting to make sense of the participant making sense of her or his experience. To do this, IPA incorporates different types of interpretation. On the one hand, it utilises hermeneutics of empathy by giving voice to the participants and aiming to understand what it is like for them. On the other hand, it draws on the hermeneutics of suspicion whereas the researcher is trying to engage with aspects of the participants' experiences that become evident in the participants' story which they

may not be aware of or perhaps are unable to talk about (Smith & Osborn, 2004). This enables the researcher to get closer to the participants' lived world, and through the analytic interpretative process the researcher can more accurately capture the experience and the context in which it occurs in.

Idiography is a study of an individual, single event. IPA is idiographic in that it focuses on the detailed, in-depth examination of the distinct experiences of each individual specific to the context they occur in (Smith et al., 2009). The researcher analyses each individual participant's story in an in-depth fashion and seeks to understand it before moving onto the next participant's story. Even when the researcher progresses onto carrying out a cross-participant analysis, she does not lose sight of the individual. It provides detailed accounts of the individual's lived experience, while illustrating how aspects of individual participants' experiences become part of more general themes across several participants (Smith & Eatough, 2006).

The theoretical foundations of IPA are in line with the aim of the current study as it seeks to explore the therapists' experiences of working with clients with CSA history and the meanings, they make for themselves based on their unique, subjective experience. The phenomenological foundations of IPA guide the researcher towards a detailed exploration of the therapists' subjective experiences of working with male survivors of CSA and will aid her in exploring the meaning therapists attach to working with their clients considering the context in which these experiences become established. The hermeneutic foundations of IPA will aid the researcher in making sense of the therapists' experiences. While the idiographic foundations of IPA will help focus her attention on the individual therapists and the in-depth examination of each therapists' experiences before she will consider the meanings elicited from cross-participant engagement with individual accounts of experiences.

2.1.5 IPA and counselling psychology.

IPA has been extensively employed across many psychology sub-disciplines including counselling psychology as it enables capturing of the experiential and qualitative of the phenomenon that the field of psychology and its various disciplines are interested in (Smith et al., 2009). Counselling psychology aims to establish a platform where the positivist quantitative scientific psychology meets phenomenologically based practice and enquiry (Woolfe, 2016). Therefore, IPA's phenomenological and idiographic foundations of focusing on the individual's subjective experience are well aligned with counselling psychology's values of recognising the uniqueness of individuals and their first-person accounts of their subjective experience.

However, IPA's aim is not to simply rely on "first-order" analysis but to progress the analysis into an interpretative level, one that does justice to the participants' accounts by describing their experiences and by offering an interpretative insight into what it means for the participants to have those experiences (Larkin et al., 2006). Therefore, IPA's hermeneutic tradition of using a systematically interpretative work to identify meanings of lived experience not readily accessible to the individual (Smith & Osborn, 2007) resonates with counselling psychology's application of various theoretical and therapeutic models of interpretation and recognition of different ways of thinking about and engaging with individuals' difficulties (Kasket, 2016). However, in IPA the researcher ought to reflect on her position, motivation and involvement in her research which contributes to the co-creation of the inter-subjective participant-researcher context (Eatough & Smith, 2017). Therefore, being aware of one's influence and using a questioning stance to one's interpretations is an essential part of the analytic process in IPA as is the reflective and self-reflexive practice of counselling psychologists' roles (Woolfe, 2016). Eatough and Smith (2017) refer to it as an "always-unfinished activity" and encourage a continuous engagement and

revising of one's interpretations to prompt the creation and surfacing of more valuable interpretations.

As the researcher's therapeutic approach to client work is relational psychodynamic, she must acknowledge the inevitable influence of her approach on her engagement with the participants and subsequently with the data as potentially this can create a tension with the phenomenological underpinnings of IPA. However, Eatough and Smith (2017) suggest that if the research is carried out with due diligence and the appropriate research procedures are followed, an interpretative style of thinking could enrich the research process (Eatough & Smith, 2017).

2.1.6 Considering other qualitative methodologies.

As alternative methodologies to IPA the researcher considered narrative analysis and grounded theory. She shall describe all three methodologies and provide a rationale for choosing IPA. IPA and narrative analysis both share an interest in the topical aspects of interaction. However, in IPA the researcher is interested in the individual's in-depth account of his personal, subjective experience which she can gain a closer access to by using her expert knowledge to interpret the participant's experience. This can assist the researcher in acquiring an understanding of what is going on for the participant that he or she may not be aware of. Narrative analysis focuses on the structural composition of meaning-making in the story told. It looks at how experiences are being comprehended and constructed by the person to achieve coherence and sense. Thus, narrative analysis concentrates on finding plots in the storied account and putting them together in an orderly manner. It aims to discover the fundamental structure of the participants' accounts (Murray, 2015). While both methodologies seek to gain a level of understanding of the participants' accounts, IPA allows closer access to the participants' experience by engagement of the researcher's expert knowledge. Thus, IPA permits a level of freedom that is not

encouraged in narrative analysis. Consequently, IPA is deemed better suited to achieving the researcher's aims.

Both grounded theory and IPA are inductive methodologies. They both use purposive sampling, and they do no rely on pre-existing theories. However, grounded theory engages in theory-building research (Charmaz, 2015). It aims to create an explanatory theory for social processes that are examined where they naturally take place. It uses the findings gained from an iterative and close comparative analysis of data to construct a theory (Lawrence & Tar 2013). Moreover, grounded theory is most suited to researching social or psychosocial processes while IPA focuses on capturing the meanings individuals attach to their experiences and the shared features of these experiences across a small homogenous sample of individuals. This research aims to explore therapists' experiences and their meaning-making of working with male survivors of CSA. It aims to do this by focusing on in-depth individual accounts as opposed to generalising findings or creating theories. Therefore, IPA is more appropriate in meeting the aims and objectives of this research.

2.2 Method

2.2.1 Inclusion criteria.

Due to the gap in the literature, and in the knowledge and understanding of this specialist work, the researcher endeavoured to recruit therapists who had a considerable amount of experience and whose accounts could have contributed to the slowly growing understanding of the complexity of the subject of male CSA. However, the difficulties inherent in finding participants for researching sensitive subjects are well documented (Ellard-Gray, Jeffrey, Choubak, & Crann, 2015), and the issues and strategies of addressing these have also been discussed in the

literature previously (McCosker, Barnard, & Gerber, 2001). Therefore, to mitigate any potential difficulties recruiting participants who met the specialist criteria, non-specialist criteria were identified to widen the pool sample of therapists in hope of increasing the number of potential participants coming forward.

Specialist Criteria:

- Qualified therapists registered with one of the following professional bodies HCPC, BACP, BPC, UKCP
- Five years of post-qualification experience
- Experience of working with at least five male clients with a history of CSA in the last five years, overall for a minimum period of three years
- Trained in the UK

Non-Specialist Criteria:

- Qualified therapists registered with one of the following professional bodies HCPC, BACP, BPC, UKCP
- Minimum of five years of post-qualification experience
- Experience of working with at least two male clients with a history of CSA in the last five years with each for a minimum of six sessions
- Trained in the UK

2.2.2 Recruitment process.

An extended description of the recruitment process will be provided as it is believed that the difficulties experienced with recruitment of participants are relevant to the complex nature of the subject under investigation.

A few months before receiving the ethical approval, the researcher contacted some of the regulatory bodies for psychologists, psychotherapists and counsellors to

enquire about advertising her research. Upon receival of the approval, she resumed contact with the organisations that agreed to post her flyer (Appendix 1) on their LinkedIn group or disseminate it via their e-letter.

She started the recruitment process in mid-September 2016 by contacting (Appendix 2) third-sector organisations like Aurora Foundation, NAPAC and Survivors UK that specialise in supporting victims with childhood abuse or CSA history. As the majority of NAPAC's work was carried out by highly trained volunteers, they were unable to assist. Considering the possibility of a difficult recruitment process, the researcher submitted a request for minor amendments to seek permission to contact those therapists who would not have met the specialist criteria but would have met the non-specialist criteria. This request was approved on the 26th of September 2016. After couple of weeks of not receiving any interest, the researcher contacted some of the university lecturers to disseminate her flyer.

Two months into not having recruited any participants, the researcher moved forward with the non-specialist criteria recruitment and thereupon she started receiving some interest. Three therapists offered to be interviewed and following the initial email exchange they simply discontinued contact. Others did not have the required experience. Therefore, the researcher submitted the second application for minor amendments which was approved on the 21st of November 2016. She removed the second recruitment criterion which required the participants to have a minimum of five years of post-qualification experience. She reworded the third criterion and the title of the flyer for greater clarity.

The researcher was able to arrange her first interview in December 2016, following which she contacted educational institutions. She resent her poster to the organisations she contacted previously, and she also wrote to newly identified ones.

She was successful in confirming two more interviews in February 2017. In March 2017, she expanded her search to the whole of the UK. She contacted rape crisis centres and sexual abuse counselling services, while also continuing to pursue organisations within the south-east of England. At this stage, two more therapists expressed interest in her study. However, following the receival of the information sheet, they terminated contact without any feedback. Subsequently, she submitted a request for the third minor amendments to have the option of conducting Skype interviews when travelling to interviews would have been too timely and costly. Her application was approved on the 15th of March 2017. In April 2017, she secured her fourth face-to-face interview. The following three months she could not secure any interviews until August 2017 when she recruited her fifth participant. Lastly, her research supervisor disseminated her poster again which yielded her final interview in September 2017.

2.2.3 Reflection on recruitment.

I experienced the recruitment process to be challenging and lengthy. Although due to recent media coverage, male CSA became a topic of discussion for many, the area of male CSA remains small and those working with them are few. This was reflected in the challenges of recruiting the desired number of participants. Despite making a few amendments to the recruitment criteria, using several sampling techniques and expanding the geographical area, the recruitment remained stagnant. Due to time constraints, the recruitment process was terminated after one year with six participants recruited in total.

While lack of interested parties could be ascribed to the scarcity of specialists in this area or professionals being busy, one question remains unanswered. Why did those who at first expressed keen interest and passion in my research, subsequently disengage without any prior indication? As I could not find a logical explanation for

the therapists' reactions, I began to question my conduct, reflected on my initial engagement with the therapists and reviewed my initial correspondence with them. I was not able to identify any errors on my part, nor did I receive any feedback. As I progressed through my interviews, I entered a new realm of therapists' experiences of working with this client group. I could not help but wonder whether the so often described sense of unbearableness of the subject of male CSA also permeated the recruitment process. The therapists communicated passion, interest, deep investment, sense of responsibility and protectiveness of their clients along with ambivalence and avoidance.

These seemingly contrasting experiences appeared to have become mirrored in their relationship with me. I wondered whether their protectiveness of their clients resulted in ambivalence towards participation. On reflection, the uneasy dynamics I picked up from the therapists' accounts led me to approach the interviews with some caution which was perhaps appropriate if it meant being respectful and allowing the therapists to take centre stage. However, I found myself holding back slightly and was worried that my questions would not be received well and would reflect a lack of experience. I felt that this has at times impacted my ability to ask the right follow-up questions. Reading the transcripts, on occasions, I appeared to have moved away from the essence of the participants' experience as opposed to posing questions that would have led me closer to them. As the interviews progressed, my caution subsided, and the interaction took on a more natural form which was aided by shared interest in the subject area.

2.2.4 Sampling.

The population sample consisted of six therapists. There is no definitive rule for sample size in IPA as the sample size often depends on several factors like the richness of the interviewees' accounts, the researcher's dedication to in-depth

analysis of the material and the constraints the researcher is under. However, as a general guide, 4 to 10 participants are considered appropriate for professional doctorates (Smith & Osborn, 2003). No gender, age or ethnic background specifications were incorporated in the inclusion criteria as they were not expected to add considerable value to the current enquiry. Nevertheless, participants completed a demographics form (Appendix 3) to provide key characteristics that might have contributed to shaping the participants' experiences and responses (Lavrakas, 2008). This information could assist in establishing the similarities and differences between the researcher's and participants' socio-cultural backgrounds which could have influenced the rapport during the interview process as well as the researcher's understanding of the participants' accounts of their experiences. Participants' ages ranged from 30 to 64. They consisted of four females and two males. Five participants were White British, and one was White Irish. One participant reported having a physical disability. The number of years of experience post-qualification ranged from 6 to 23 with the average being 12 years. The number of years of working with adult males with CSA history ranged from 3 to 20 with the average being 9 years. Participants worked with between 3 and 40 males with CSA history.

Table 1: Participants' demographic details

	01: Lucy	02: Paul	03: Paula	04: Liz	05: Adam	06: Emily
Age	30 - 49	30 - 49	30 - 49	30 - 49	50 - 64	50 - 64
Ethnicity	White British	White British	White British	White Irish	White British	White British
Disability	No	No	No	No	No	Yes
Regulatory body	HCPC / BACP	UKCP	HCPC	BACP	BACP	HCPC
Years of experience post-qual.	11	11	6	8	11	23

Theoretical orientation	Existential	Psychoanalytic	Integrative	Psychodynamic	Transpersonal / Integrative	Integrative
Years working with adults with CSA	3	11	9	4	5	20
Clients with CSA history	15 - 20	Approx. 8	150 - 200	Approx. 12	25+	60+
Male clients with CSA history	15 - 20	Approx. 6	15 - 20	Approx. 10	3+	40+

2.2.5 Interview schedule.

All participants were interviewed individually. Five interviews were conducted face-to-face, and one interview was conducted via Skype. In accordance with IPA, a semi-structured interview schedule was created (Appendix 4) consisting of nine questions about how therapists came to work with male CSA survivors, their experiences and challenges of working with this client group, changes in their practice and their meaning-making process. The interview schedule was used simply as a guide to ensure that the objectives of the study were met. The interviews were conducted in a person-centred manner to facilitate a natural, free-flowing conversation where the interviewees could talk about their experiences without interruption or pressure to restrict their narratives to specific questions. The flow of the interviews varied. Some of the interviewees appeared to be more aware of the interview schedule. This was evident in the interviewees waiting to be asked a question or checking with the researcher whether they have fully answered her question. Others were found to answer most of the questions naturally within the free flow of the conversation. The researcher also found that she felt more at ease with some of the interviewees and enjoyed the natural development of the dialogue. The research project came alive in these conversations, and she became more aware of her role in shaping the interviews and of the relational dynamic that shaped each interview slightly differently.

2.2.6 Interview process.

The interviews were arranged to suit the participants. This was partly to express gratitude for giving up their time and partly to help increase their sense of safety and comfort to engage about their experiences more freely. Four interviews were conducted at the participants' workplaces. The interview with Liz was conducted in her home, and Emily's interview was conducted via Skype without the knowledge of her exact location. Travelling to the participants' preferred locations, the researcher ensured her safety by following the University's Lone Working Policy (Appendix 5). She always informed someone of her whereabouts and agreed to contact them upon arriving and leaving the interview location.

She started each interview by expressing her gratitude for taking part in the research. She explained that she would begin by asking them to read the consent form (Appendix 6), and they could ask any questions arising from reading it. After they signed the consent form, the researcher explained the interview style she was using which meant that she had a set of questions that she would refer to from time to time, but by large she hoped for them to feel free to talk about their experiences in as much detail as they were comfortable to. She reminded them that the interview was going to be audio-recorded and asked for their permission to turn the recorder on when they were ready to start.

2.2.7 Reflections on the interview process.

Particularly at the beginning, I was aware of the power dynamic between myself and the therapists. I presented as a trainee counselling psychologist, a novice researcher of qualitative research, a woman of non-British ethnic background interviewing therapists who were qualified professionals with a considerable amount of experience in their field and all Caucasian from the United Kingdom. This experience was

somehow heightened by me sitting in the interviewer's chair asking them to share their experiences with me. However, as we progressed with the interviews the differences subsided, and in most cases the interview took on the shape of an organically evolving dialogue between two parties who shared a passion for the same subject. One of the interviewees provided me with a constructive feedback regarding a couple of the interview questions. This was a refreshing experience as it challenged and expanded my perspective on the subject matter and confirmed my hope for the interviewee to be comfortable enough to question and engage with me in a discussion. One participant struggled to understand the interview question about the meaning-making process. This aided me in reflecting on the question from the participant's point of view and acknowledge that I would have probably struggled to answer it too.

2.3 Ethics

2.3.1 Ethics approval.

The initial research proposal was submitted for the consideration of the ethics committee under the reference PSYC 16/234 in the Department of Psychology, and the research project was approved under the procedures of the University of Roehampton's Ethics Committee on 12/09/2016 (Appendix 7). This research project was carried out conforming to the British Psychological Society's Code of Human Research Ethics (BPS Code of Human Research Ethics, 2015) and in compliance with the ethical guidelines of the University of Roehampton and the University's Code of Good Research Practice.

2.3.2 Participation consent and right to withdraw.

Participation in the study was voluntary. Potential participants who expressed interest to participate were sent an Information Sheet (Appendix 8). If they expressed

continued interest, the researcher proceeded to arrange a time and place to conduct the interview. Before the start of the interviews, the participants were given a formal written consent form to read and ask any questions arising from reading it. Before giving their informed consent, participants were reminded that their participation was entirely voluntary, and they had the right to withdraw from the study or modify their consent at any time as specified in the BPS Code of Human Research Ethics (2015). The consent form also specified that if the participants wished to withdraw from the study after submission of the doctoral thesis, their data could still be used in a collated form. Moreover, if they wished to withdraw from the research, they were required to contact the researcher with the ID number and their data would be removed accordingly. After the participants and the researcher were happy to continue, the signed written consent forms were obtained from each participant.

2.3.3 Participant anonymity, confidentiality and data storage.

Subject to the Data Protection Act 1998, all data were treated confidentially and anonymously throughout the research. All identifying information was removed from the data. The participants' identifying information was replaced by pseudonyms in the transcripts to maintain their anonymity. Consent forms were stored securely and separately from the research data in a locked filing cabinet. All non-anonymised information is being preserved securely for 10 years and then destroyed. All participants were given ID numbers which were linked to the participants' pseudonyms in the transcript but were not linked to their real names. All research data and recordings were identified with the participants' ID numbers only. All research data is securely stored on a password-protected, encrypted hard drive. Any hard copies of audio recordings are securely stored in a locked case separate from any identifying information. This research study conformed to CREST's Data Storage Protection Guidelines (Appendix 9).

2.3.4 Participant distress.

There were no expected risks for therapists who took part in the study. However, some participants could have experienced discomfort answering questions about their work with male clients with CSA history or could have been inconvenienced by giving up their time to participate in the research. If a participant had experienced any discomfort due to participation in this research, they would have been able to miss out questions or withdraw from the study without providing any reasons. Following the interviews, all participants were provided with a written debrief form (Appendix 10). The participants were offered a chance to share their thoughts and ask any questions. The debrief form contained a list of contacts for emotional support should have there been any further concerns arising from the research which could not have been resolved in the debrief session or which would have come up afterwards.

2.3.5 Potential benefits to participants.

Therapists participating in this research had an opportunity to reflect on their experiences and meaning-making process of working with male clients with CSA history. This had potentially highlighted significant aspects of their experiences that they might not have had the opportunity to explore and reflect upon previously. Therefore, therapists could have gained greater insight into and awareness of their experiences and consequently increased their professional efficacy (Sommer & Cox, 2005).

2.4 Transcription

Following the completion of the data collection, the researcher transcribed the audio-recordings of all interviews including all her questions, comments and interjections. She paid particular attention to and made note of pauses, sighs, laughter, gestures and verbal utterances, such as “hmm”, “um”, “argh” to capture all the nuances that

make linguistic expression richer and allow production of a transcript that is close to the participants' original accounts of their experiences. Transcriptions were written on Word documents in a landscape orientation with each line and page numbered for ease of reference. A substantial margin was left on the right-hand side of the text to allow for initial notetaking and a smaller margin was left on the left-hand side of the text to allow for noting emerging themes.

2.5 Data Analysis

2.5.1 Analysis procedure of individual transcripts.

The researcher completed the transcription of all interviews before she commenced the analysis. She analysed one transcript (Appendix 11) at a time and finished analysis of one interview before she moved onto the next one. She read and -re-read each transcript. During the initial readings she listened to the audio-recordings to bring her attention to the language and the intonation. As per the example in Smith et al. (2009), the researcher used three colours to note sections of the text and to write her initial notes in the right margin. These were used to represent three categories of comments: descriptive, linguistic and emotive. The researcher used this system of categorisation of initial notetaking loosely as it served as a tool to engage with the text at a deeper level which she found particularly beneficial in the initial phases of the analysis. Once she reached a level of depth and became more familiar with the process of analysis, intuitive engagement with the text became just as important. The initial notes were then broadly categorised into initial emergent themes which consisted of a phrase or few words using more psychological terminology that captured the essence of a paragraph or a participant's thought. At this stage, the analysis moved from descriptive to conceptual or interpretative (Larkin et al., 2006). Re-reading the text was an essential part of this stage of the analysis to ensure that the initial themes reflected the themes in the original text.

2.5.2 Emergent themes.

The researcher transferred the initial emergent themes onto a new document in a chronological order (Appendix 12) along with quotes from the original text that best evidenced the emergent themes. The quotes were labelled with the page number and the line number that referenced their position in the original text. Subsequently, she examined the emergent themes for clustering. The emergent themes that clustered together were given superordinate theme labels and these were again transferred onto a new document (Appendix 13). This process was carried out with each individual transcript.

2.5.3 Superordinate themes.

Lastly, the researcher examined each participant's list of superordinate themes and looked for connections between them which allowed for the creation of the superordinate themes for the group of participants. During this process, she continued to engage with the original text to ensure the reliability of themes. At every stage of the process new insights emerged, and this required several changes to the superordinate themes and their subthemes.

2.5.4 Reflections on the analysis.

Reflections on the analytic process were vital in assisting me to become more aware of my process and its impact on the data analysis. I experienced the analysis to be a complex, challenging and lengthy process. At times, I felt very engaged with the data and got easily immersed in it; other times, I found it tedious. Mostly, I felt overwhelmed by the enormity of the task of analysing the participants' accounts. A real sense of discomfort took over me at the point of creating the initial emergent themes when I moved away from the descriptive level of engagement with the text and moved into a more interpretative style. I felt conflicted as on one hand, I enjoy engaging in interpretative styles of working, and this was no different when I was reading the

original transcripts. On the other hand, I felt as if I was betraying the participants by doing more than just engaging with the text at a phenomenological level.

I felt torn as I imagined that the participants would not feel comfortable with me making interpretations of their experiences. For instance, at times I felt that the participants' approach intended to protect their clients, while reading the transcripts it also became evident that they were finding ways to protect themselves from the fear or discomfort they experienced working with their clients. During these moments, I felt excited about getting closer to what was happening, but I also felt uncomfortable about the prospect of imposing an understanding that they were not ready to see or talk about openly. However, I knew that a level of interpretation was necessary to get closer to the participants' actual experiences, including aspects of their experiences that they may not have been aware of. Consequently, close evidencing of the themes became more than just the essential part of good IPA practice but also a desire for the outcome of the analytic process to represent the participants' experiences.

I also had to acknowledge my preconceptions that I became aware of as I found myself struggling with one of the participant's accounts. As I grappled with this material, I needed to understand my difficulty with it which for me meant reflecting on my feelings and thoughts that the participant's material brought up for me. Through my reflections I realised that it was the therapists' unspoken discomfort and their struggle with the work that I found difficult to engage with. The seeming lack of insight that became subtly evident through the analysis of the text made me somewhat angry and protective of the clients. However, awareness and acknowledgement of my pre-conception was integral in addressing it and finding a way to empathise with the therapist's experience. Being able to challenge my preconceptions and reflect on the change in my feelings towards the participant's material felt rewarding.

2.6 Quality in Qualitative Research

Qualitative research uses a naturalistic approach, and it seeks exploration, uncovering and understanding of phenomena. While quantitative research applies statistical procedures in controlled settings with the aim of determining causation, prediction and generalization of outcomes (Graziano & Laurin, 2010). Validity and reliability as concepts that have been used to evaluate the rigour and credibility of a research are widely accepted in quantitative research. However, their relevance, appropriateness and applicability to qualitative research have been questioned (Bashir, Afzal, & Azeem, 2008; Stenbacka, 2001). Consequently, most qualitative researchers address the issue of quality and credibility through concepts they developed to best suit qualitative research. For instance, Leedy and Ormrod (2005) offers the following set of criteria to evaluate qualitative research: purposefulness, explicitness of assumption and biases, rigour, open-mindedness, completeness, coherence, persuasiveness, consensus and usefulness. In addition to the need to establish appropriate concepts for evaluating qualitative research, the issue of using the same set of criteria for different types of qualitative approaches have also been raised.

The importance of specificity of criteria for different qualitative approaches has been pointed out by Smith (2011). In response to the lack of specificity that generic qualitative research criteria were able to offer, Smith (2011) described the characteristics necessary for a good IPA research. These are good interviewing skills, qualities of rigour and interpretative skills; plausible and convincing evidence which is in support of the stated claims and skilful presentation of the interpretation. He also developed the IPA quality evaluation guide which states four criteria for acceptable IPA. First, it must be clearly underpinned by the theoretical foundations of IPA; phenomenology, hermeneutics and idiography. The present research chose to use IPA as its philosophical underpinnings were in line with the aims of the research, i.e.

gaining insight into the therapists' individual, subjective experiences of working with male survivors of CSA history. Second, it must be transparent to the reader. The researcher has taken care to ensure that the entire process of conducting and writing up this research has been described transparently to provide the reader with clarity. Third, it needs to be a coherent, plausible and an interesting analysis. The researcher endeavoured to ensure that the analysis reflects the participants' accounts of their experiences accurately and coherently to engage the reader. She believes the findings reflected in the analysis are interesting and will provide the reader with a greater understanding of the therapists' experiences of working with male survivors of CSA. Finally, the sampling must demonstrate density of evidence for each theme. The researcher believes the themes identified are representative of the therapists' experiences, and they are evidenced by example quotes from participants which can be traced back to the original transcript.

Chapter 3 – Findings

The next chapter provides the findings of the Interpretative Phenomenological Analysis, which was conducted on six verbatim semi-structured interviews with therapists who have extensive experience of working with male clients with a history of CSA. The researcher presents the results of the analysis by discussing each superordinate theme and its subthemes. The themes are explored, illustrated and evidenced by example quotes from the interviews that were found to best capture them.

The researcher recognises her subjectivity in interpreting the data during the analytical process, and she is aware that a different researcher might have focused her attention at other aspects of the interviews and would have likely interpreted the

material differently. The researcher appreciates that it is not feasible to include all the material provided by the participants. However, despite the uneasy decisions to edit or exclude material, she hopes that she will be able to honour the therapists' work and give voice to their experiences as it is with huge gratitude and strong sense of responsibility that she approached the analysis of the transcripts.

Table 2 - Summary Table of Superordinate Themes and Subthemes

SUPER-ORDINATE THEMES:	1. Impact of Societal Attitudes Towards Male CSA on the Therapists' Work	2. The challenging nature of male CSA work	3. Taking care of self	4. Caring about the clients
Subtheme 1:	Parallels between the clients and the therapists	Personal lives invaded	Professional support	Feeling protective of the clients
Subtheme 2:	Therapists' sense of helplessness	Professional challenges	Managing the therapeutic encounter	Providing safety for the clients
Subtheme 3:	Therapists' attitudes and perceptions of male CSA	Contrasting experiences – from feeling passionate to feeling overwhelmed	Personal self-care	

3.1 Superordinate theme 1 - Impact of Societal Attitudes Towards Male CSA on the Therapists' Work

The first superordinate theme is the "Impact of Societal Attitudes Towards Male CSA on the Therapists' Work" as the therapists' work with their clients becomes affected by societal preconceptions of masculinity and male CSA. The therapists find that their experiences resemble their clients' challenges that appear to stem from society's position towards male CSA. The societal attitudes become barriers to the therapists' work and leave the therapists feeling helpless. Finally, the therapists' reflections show that different aspects of their lives, such as work, training and personal life have in

some ways helped them to broaden their perspectives and aid their work with a group that they themselves may have not always been open-minded or informed about.

3.1.1 Subtheme 1 - Parallels between the clients and the therapists.

According to the therapists, the male survivors of CSA often face disbelief, minimisation or misrepresentation of their CSA experiences by society which has been reported to impact their ability to speak out and receive much needed support. Working with these clients, the therapists also found that through lack of awareness of the issue of male CSA, their clients' experiences were downplayed or not given much consideration. In other cases, understanding of the complex and unsettling nature of male CSA contributed to decline of any involvement with clients with male CSA history. This had a profound impact on the therapy and the therapists' work.

Some of the therapists witnessed the societal legacy of CSA playing out in their work with their clients which led them to encounter experiences similar to that of their clients.

Lucy's client suffered from CSA related mental health difficulties which were thought to have been exacerbated by the complex circumstances he found himself in through receiving a deportation order and through a lack of support available to him within the mental health system. Lucy believed that her client needed more support than the charity organisation she worked for could offer him. The challenges of his unstable circumstances and worsening mental health complicated by societal and cultural attitudes towards the issue of male CSA were evident in his presentation in the therapy room and in Lucy's counter-transferential encounter of him.

> his chaos was um… was really hard for him and I felt it in our sessions, sometimes I got a flavour of that chaos and it wasn't nice, it wasn't nice. Um

> but there were so many things about his environment, society that were playing into that chaos, I think […] What? What is real? What has happened and what hasn't happened? What he imagined? or what he's fearful of? ... and just being very um, chaotic and confused. I'd be confused. (Lucy 9:243)

Lucy's account emphasises the confusing nature of her encounter. She witnessed the effects of her client's circumstances on his wellbeing. There was a sense of heaviness as she paused to look for words to describe her experience of him. She felt his struggle, and sometimes it affected her own experience of him. She recounted the multiplicity of factors that contributed to the disorder he was in. She tried to explain what it was like for her, what that chaos looked like. Lucy was not sure what her client experienced or what he only imagined. Her inability to ascertain her client's situation appeared to have led Lucy to experience a similarly uncertain relationship to reality, leaving her feeling confused amid her client's chaos.

Adam described a halt in the therapeutic process due to his client not being able to come to terms with his CSA. Adam believed that the lack of general societal awareness of male CSA makes the abusive experience for males that much more traumatic and difficult to process: "we seemed to come to a point where he would just be asking what kind of a human being would do that and there, we would get stuck. Um, he couldn't then process it much further" (Adam 4:96). Adam's client was in disbelief about his mother being capable of abusing him and he couldn't move beyond that. Attuning to Adam's difficult position of not being able to help his client achieve a shift in his emotional world, a parallel experience of stuckness can be observed.

The effects of lack of societal engagement with the occurrence and impact of male CSA was also experienced by the therapists outside the therapy room.

Emily shared her experience of liaising with a solicitor regarding her male client who suffered CSA:

> a solicitor […] basically implied that being sexually abused on top of all the other things (childhood traumas) that had happened therefore hardly, hardly had an impact […] Interviewer: How, how do you work with that? Emily: Get angry first (snickers) but don't write anything back (chuckles). I get angry, um and then I go into, I mean I personally I kind of switch into what I call psychoeducation mode. (Emily 17:504)

Whilst the solicitor was aware of Emily's client's history of CSA, it is apparent that he may not have been aware of the devastating effects of this on his life and how it may have contributed to his incarceration. Emily indicated her frustration with the solicitor's lack of understanding of the impact of CSA and spoke about needing to contain her reaction before she could address him. Emily found herself in a similar position to her clients whereas her assessment of her clients' CSA experiences was not attributed the weight it was ought to.

Similarly to how male CSA survivors feel that they are being silenced: "the reality is evil's done to you and there's no redress, you just sink into silence" (Adam, 17:490), therapists described feeling that their voices have been suppressed by the apparent lack of interest and perhaps fear to engage with the subject of male CSA.

> It's personally very hard, I think because (pauses) I think that there is a real reluctance in society um to acknowledge that it even happens. Um, so that makes it difficult to talk about. So, I think there is a silencing even of psychologists and therapists. There is a silencing not only of the victims but the people who work with victims. (Emily 14:421)

Emily's account of the effects of the societal attitudes towards male CSA on her work highlights the difficulty this poses on being able to effectively work with male CSA within a social and cultural system that is perhaps not quite ready to address the complex nature of this issue.

Lucy faced questions of disbelief when she spoke about the client group she worked with.

> I think that in society there is still a lot of denial, even when I say where I work, they're like: "What"? Well, how does that work?" Especially if the perpetrator, the perpetrator is a woman. It brings up a lot of things of: "Well, how can that be?". (Lucy 13:388)

Lucy believed that the denial of male CSA was still highly prevalent in society. A simple question about her place of work turned into an awkward conversation where Lucy had to explain and defend the reality of her clients' experiences. The reaction Lucy received from others reflects the lack of understanding of even the physiological possibility of male children being sexually abused.

Societal attitudes towards male CSA also affected the therapist's supervision:

> Supervision was really hard um because I couldn't find any appropriate supervision. […] it was very interesting. A couple of them didn't want to supervise the, the, the, the men who had, my client work with men who had been sexually abused um and in fact said that it was too disturbing. So, I was, I got, I experienced a parallel experience of my clients looking towards supervision. (Emily 19:559)

Emily's initial experience of supervision was challenging. Instead of being supported by an appropriately knowledgeable supervisor, she was searching for anyone willing to help as some found the subject of male CSA too unsettling. This exacerbated

Emily's level of aloneness in her work which made her identify with her clients' experience of being denied support.

3.1.2 Subtheme 2 – Therapists' sense of helplessness.

The majority of the therapists experienced a sense of helplessness in their work with male CSA survivors which appeared to have been underscored by societal attitudes towards male CSA. The therapists' sense of helplessness manifested on two levels; within the therapeutic encounter and via the response of services/society (e.g. supervision, courts).

Some therapists experienced a sense of helplessness when societal attitudes towards male CSA had an impact on their own ability to help their clients.

Adam's thoughts focused around his own powerlessness to help his clients to move forward:

> maybe there is a sadness around it not being able... these things [CSA shaping lives] can't be reversed, you know. […] They seem to be constantly tripped up by their past experiences. Even if we talked them through, you know gentle kind a way when they raise the, the subject, um they were still traumatised. (Adam 13:352)

There is a sadness surrounding Adam's experience of his client's abuse not being reversible. Adam seemed to have found himself in an impossible position, where no matter what he does his clients always stumble. "I think people just struggle […] that's not actually a great outcome. […], but they carry it with them. It, because it's not, it's not socially acceptable. It's not, um there's no healing story for them". (Adam 14:411). Adam feels that due to male survivors' experiences of CSA not being socially acceptable there is no possibility for a different outcome than the one he keeps

reexperiencing with his clients. His wish for male CSA to be reversible speaks loudly about his sense of helplessness.

Some therapists reflected on their own professions' capacity to help male CSA survivors: "I feel very pessimistic about how, how well as a profession we're able to, to treat these very severely troubled and damaged patients" (Paul 28:815). Paul felt doubtful about therapists' ability to help male clients with CSA history. He communicated clearly the depth and the extent of the challenges these clients require support with, and he insinuated that therapists may not have the skills to help them.

A sense of helplessness was also felt by the therapists when witnessing systemic dismissal of male CSA survivors' needs.

Emily experienced this as she witnessed the justice system failing to recognise the effects of CSA on her client.

> I find it very difficult um to watch the um basically the courts um (pauses) I am not gonna say ignoring but sometimes discounting the early histories of people when they're considering punishments, outcomes, sentences. (Emily 14:424)

Evidently, Emily struggled with being in a powerless position where she could not do anything but to stand by seeing the courts making rulings about her clients' futures without understanding and acknowledging the effects of their victimising experiences on their lives.

A sense of helplessness was also felt where a lack of support was identified outside of the therapy room.

For example, Lucy grappled with feeling powerless working with clients whose needs warrant support at a systemic level, yet they only receive support from a once weekly session with a therapist: “the whole of society was just kind of letting him down and I found that really challenging because one person for one hour a week, what...what can you do” (Lucy 7:206)? Lucy’s account emphasises her experience of battling with a sense of urgency to help her client whilst needing to accept the limits of her support. She could only offer him her presence and openness for him to share his pain with her once a week. However, Lucy was acutely aware that her client needed a lot more than what she could offer him. There was a reluctance and yet an awareness of needing to accept having to stay with her sense of helplessness.

3.1.3 Subtheme 3 – Therapists’ attitudes and perceptions of male CSA.

The therapists reflected on their perceptions and attitudes towards men and the issue of male CSA. In some instances, their reflections indicated commonality with frequently held societal beliefs and attitudes. However, it also became apparent that different aspects of their lives helped to shape their perceptions which influenced their attitudes towards their work with male CSA survivors. For some of them, working with men broadened their ideas of maleness and helped them to recognise that CSA is not a female issue.

In Lucy’s case, having sons and seeing different sides to men in the therapy room changed her perception of men in general.

> (witnessing her client’s stereotypically masculine and vulnerable sides) seeing the bigger picture, in the whole, the more holistic view and I do wonder, I’ve got three sons and I do wonder whether that was an element as well, just seeing them grow up and there is some stereotypical behaviours they do and

> then other times not at all and I think perhaps that sort of opened my mind as well to not falling into stereotypes and being open to the whole person. (Lucy 2:35)

Seeing different sides to men in the therapy room, helped Lucy to create a more realistic picture of men. She reflected on how being a mother to three sons and seeing them act in ways that conformed as well as deviated from the masculine norm also contributed to her being more open to seeing men as complete individuals.

Working with both men and women with CSA history was also identified as helpful in not seeing sexual abuse simply as an issue concerning women. “I think seeing both men and women um (pauses) who have experienced um sexual violence in childhood or adulthood um (pauses) helps to make it less of a um female problem or particular gender problem” (Paula 27:739). Reflecting on Paula’s use of language, she spoke in general terms as opposed to clearly attributing the experience she was describing to herself. However, she indicated that before working with men with CSA history she attributed the issue of CSA more to women and the opportunity to work with men allowed her to see CSA as affecting both genders.

The therapists also talked about their experiences of the lack of acknowledgement of the issue of male CSA while insinuating that they might have shared this attitude in the past: I think it’s something also quite people are in denial and I think um working here, not that I was in denial before (Lucy 6:178)

Lucy described her experience of others avoiding the facts of male CSA and drew on her own experience of working at a service that specialises in working with this client group. She stopped mid-sentence and clarified that she was not in denial prior to working at the service. Lucy’s wish to clarify her own position indicates that she may

have held some preconceptions about CSA. However, her work contributed to her increased awareness.

3.2 Superordinate theme 2 – The Challenging Nature of Male CSA Work

The second superordinate theme captures the demanding nature of male CSA work which is experienced to have a significant impact on both the therapists' personal and professional lives, threatening the boundaries between the two and having lasting consequences on their engagement with this work despite its recognised value. The issue of male CSA invades the therapists' personal lives by occupying their thoughts and by forcing them to re-evaluate their perception of the word around them. The professional challenges reveal the male CSA specific issues the therapists are challenged by when supporting their clients in coming to terms with the repercussions of their CSA history. The complex nature of male CSA is also evidenced by the therapists' complicated relationship to it. The therapists express strong feelings of excitement, passion and attribute much importance to the work. However, the challenges they face appear to outweigh their passion for it and force them to acknowledge their limitations of undertaking this work.

3.2.1 Subtheme 1 – Personal lives invaded.

Male CSA work had significant effects on their personal lives of most therapists. Negative consequences were more intense than with other client groups. The therapists became preoccupied with the subject of CSA. They also reported growing safety concerns for themselves and their family members and changed perceptions of their communities and their world view. These fears resulted in increased hypervigilance. They also described blurring boundaries between their personal and professional lives.

Some therapists found that listening to the survivors' stories of being sexually abused affected their personal lives by making them feel that the world around them was less safe. For example, Lucy spoke about the impact of this on her as a mother: "having children of my own um I am probably verging on (laughs) paranoid about who looks after them and extracurricular activities and things like that. So, it had an impact um personally" (Lucy 16:476).

Lucy described the magnitude of the impact of the abusive stories on her. It was affecting her personal life as it was changing her perception of the world her children lived in. It made her think of it as more dangerous and caused her to be more alert and cautious. She laughed when she described herself as "verging on paranoid" which indicated that she was aware that she might have been unduly distrustful of those looking after her children. But it was also a testament to the impact of the stories on her. Perhaps Lucy felt somewhat embarrassed about sharing her experience with the interviewer and introducing laughter into the conversation lightened the perception of her experience and made it easier for her to share.

Liz was also beginning to feel the impact of listening to the survivors' stories.

> There are (challenges), and I am really starting to feel it recently, um. It's just a level of really dark stories that you know I get to hear. I am very, I am not faced, I am not easily shocked. Um, or sometimes I am shocked but not really with the material that clients bring, it doesn't surprise me anymore. (Liz 9:248)

Liz expressed feeling challenged by the effects of the dark stories. She was describing her experience in a slightly disjointed manner perhaps trying to express the essence of her experience. The stories no longer had shocking effect of a novel unsettling experience, yet some aspect of them continued to be troubling her.

As Liz carried on, she remembered a client's story that had a particularly powerful effect on her due to the proximity of the abuse described in the story to the area Liz lived in.

> I felt that, that was tarnishing my, my area. So, when I was walking past that road, I was going eww. So, I would find I am carrying clients, certain clients sometimes because um I hear about really murky, quite horrific things that happened around here. So, that, that does, and I really have started to feel a build-up with that. (Liz 9:264)

Liz described how she felt when she walked past the street her client talked about. She felt disgusted by the thought of the abuse happening near where she lived. Knowing that something as awful as male CSA was happening in her area changed her perception of her neighbourhood and challenged her sense of safety: "my sense of safety! Yeah, exactly!" (Liz 10:275).

As the interviewer reflected on Liz's previous account when she spoke about the stories no longer shocking her, there was a sense of being closer to her experience. She was no longer shocked by her clients' stories, but the accumulative effect of the continuous exposure to the stories were weighing on her and she started to internalise them. Moreover, hearing about stories of abuse that were perpetrated on her doorstep resulted in Liz feeling that in some way her sense of safety became threatened. Therefore, Liz could no longer mentally separate her work from her personal life as her own surroundings became reminders of stories of abuse from work.

It appeared that safety fears grew into a changed perception of the communities in which the therapists lived. Seeing everything as more "dark" or unsafe. Perhaps the

therapists' immediate safety fears for self and loved ones developed into a wider change in the way in which they viewed the world around them.

It also became apparent that to a degree the therapists' professional and personal lives were combining in that the boundaries between work and personal life became blurred, providing some indication for the reason the negative effects of this work seem to be more severe for the therapists.

Some therapists felt that they could not bracket off their work, and it was experienced as taking over their lives. For instance, Paula felt that she could not escape the thoughts of sexual violence. "I am thinking about sexual violence an awful lot which isn't that nice to be honest (smiles), I prefer to be thinking about other things (laughs)" (Paula 27:754). She described a preoccupation with the subject of sexual violence which she felt was beyond her control. She smiled as she emphasised her powerlessness over what was happening to her by explaining that it no longer felt like a choice. She was concerned with the vastness of the issue of sexual violence, its saturating effects and her inability to escape them: "it's everywhere, isn't it? You can't get away from it and that's horrible" (Paula 29:796).

There was something about the therapists' sense of intensity of their experiences working with this client group that felt as if it could not be contained within the remits of the therapeutic space and which would be experienced as taking over their lives: "I think, I think it's so much more than just a transference that we might write down or, or kind of battled out it's a, it's a total transference you know, it's, it's everywhere for a while and …(pauses and sighs)" (Paul 26:770). Paul described his experience using psychoanalytic terminology of transference which refers to the redirection of emotions to him as a therapist that his patient experienced in childhood. He found his experience to be considerably more intense and far-reaching than he would have

expected usual transference to impact him and similarly to Paula's experience, it appeared to have affected his personal life.

3.2.2 Subtheme 2 – Professional challenges.

The therapists not only experienced the impact of working with male survivors on their personal lives, but they also felt particularly professionally challenged. They felt tested working with their clients' anger, sense of shame and self-blame, their difficulty to disclose for fear of being disbelieved, as well as to admit and accept that they were sexually abused. Although, these issues were not experienced as specific to male survivors of CSA what differentiated them from female CSA survivors and other client groups was the high levels of emotional intensity which subsequently posed a greater barrier to effective working with male CSA survivors.

Therapists seemed to agree that working with survivors of male CSA was more challenging than working with other clients. "Some of the clients here are more challenging than other places where I've worked" (Lucy 18:525). Paul echoed Lucy's experience: "definitely one of if not the most difficult patient I've ever seen" (Paul 24:718).

There were a number of reasons the therapists identified that made them feel particularly professionally challenged by this client work. Paul appeared to have found the complexity of his client's presentation very challenging to work with and it resulted in a highly chaotic therapeutic dynamic that made both him and his client struggle to bear it: "I think some amount of mess is, is necessary but it was so messy that both he and I found it almost intolerable to do the work" (Paul 23:664).

Emily found the work: “very emotionally challenging, um very there is very much the sense of needing to be totally present with, with the people in the room, in the therapy room, the person in the therapy room no matter what they’re bringing. (Emily 12:364)

Emily found the work highly emotionally demanding. She made sense of this by recognising that her clients needed her to be fully present regardless of the heaviness of their material. Emily’s experience resembled a mother’s role of needing to give her baby her undivided attention and needing to put her baby’s needs before hers.

Others felt challenged by their clients’ anger which they felt was more intense than female CSA survivors’ anger: “female clients can be angry too, but male clients are angry, they are (pauses)” (Paula 22:603). This has affected the therapists’ sense of safety: “I remember feeling like, you know, I don’t know whether I can work with this client. It’s too, it feels too threatening (Liz 13:379)”. At times, this was prompted by knowledge of their clients’ violent history: “some clients that I was anxious about working because of the violent history (Paula 25:685)”.

Higher levels or more overt expressions of anger in male clients not only affected the therapists’ sense of safety whilst with their clients, but it also made it harder for them to help their clients work through their anger: “it’s harder to get them to kind of recognise and get them to be vulnerable and it is harder to work with their anger“ (Paula 22:613).

Another issue the therapists found to be more prominent in male CSA survivors was disclosure of their experiences: “It's getting them to even talk about it (Adam 3:88). The challenges that the process of disclosure presented to men was according to Lucy also recognised by the service she worked for. The organisation offered the male CSA survivors two years of therapy due to evidence suggesting that they took

longer to talk about their experiences. Lucy also experienced this directly in her work: “I’ve certainly seen that in my client work. Um, it took one of my clients about nine months to be able to actually talk about the abuse and luckily, we had two years” (Lucy 4:106).

Emily felt that the disclosure was about the client’s ability to learn to trust her to tell her about their abuse whilst risking that she would not believe them. She thought that it was the depth of the fear of not being believed that set apart the men’s and women’s experiences:

> This is one of the things that really separates the male victims and the female victims. I'm not suggesting for a minute that female victims don't fear that they won't be believed, because it's a common fear, but the depth of it in men, in my experience, is it's profound. (Emily 17:409)

The male survivors’ level of shame and self-blame was also perceived to be harder to work with:

> it's easier with other clients who carry even a sense of shame to talk with them and get them to recognise that perhaps the self-, self-blame they feel um isn't appropriate. Whereas, actually, I think it's much harder to work that through that with males who have been sexually abused. It's, it's a, it's a, it's a greater struggle in the, and it's interesting I used that word, in the therapy room (Emily 2:58).

Emily found that male CSA survivors struggle to shift their sense of shame attached to their abusive experience more than other clients do. Emily used the word “struggle” to describe what happens in the therapy room as a result of trying to redirect her clients’ sense of self-blame. She, herself, found the use of her word intriguing.

Perhaps verbalising it allowed her to get more in touch with her experience of the challenging nature of the work.

Lucy experienced perhaps the most difficult of experiences a therapist could face, losing a client: “I think with this client group I’ve had to face some of my biggest fears as a practitioner. Um, so I’ve had a client who committed suicide. I’ve had um my notes called for court.” (Lucy 10:288).

3.2.3 Subtheme 3 – Contrasting experiences – From feeling passionate to feeling overwhelmed.

Despite the challenges of male CSA work, the therapists felt positively strongly about this client group. They had a strong desire to share their experiences which were filled with emotionally charged stories and they attributed great significance to the issue of CSA. However, despite their passion the challenging nature of the work also brought up difficult feelings in the therapists which contributed to their caution when considering their workload with this client group.

The therapists spoke about their enthusiasm as well as their overwhelming sense of the work with male CSA survivors.

Emily shared her contracting experience of her work. As she finished speaking, she sighed heavily and then added:

> that sums up how I feel about working with these clients, and it’s hard to put into words. I feel that this is so profound, so far reaching and I will say positive, positively of such importance, but I, but it feels ab… quite regularly overwhelming. (Emily 10:282)

Emily struggled for words as her experience felt beyond description. Few times she sighed during the interview which she reflected on and used it to explain the extent of the impact of the work and its significance on her. She was evidently passionate about her work but also found it overly intense.

Emily's contrasting experiences of feeling passionate yet overwhelmed about the work with male CSA survivors were echoed by Paul's experience: "I probably sound you know passionate and excited and engaged and all this stuff. I am also horrified by it" (Paul 27:785). Paul reflected on how his expression of his experience might have been perceived by his listener. He sounded passionate and enthusiastic about the subject of male CSA which he said was the reason for his participation in the research. However, he also experienced the work terrifying.

In light of the therapists' contrasting yet coexisting experiences, they spoke about their choice to limit work with this client group due to its highly demanding nature.

The interviewer asked Emily whether this was her main employment, to which she replied: "No, (smiled) and I will say that's quite deliberate. I don't think I could. I don't think that I could do this certainly all the time […] for me it is too challenging to take on more um than that um in, from this client group" (Emily 10:289). Emily described making a conscious decision to only work with on average six male CSA survivors per year. She doubted her ability to attend to this work on a full-time basis.

Liz shared Emily's experiences "I think it's important not to have too many clients with um you know with this kind of childhood sexual abuse trauma issues." (Liz 10:276) Paul echoed their experience: "if those were the kind of patients, I saw day in and day out I don't think I could do the job. So, I think for me it has to be very, very rare, very occasional work" (Paul 27:793). Paul could not imagine working as a therapist if he

was only treating male survivors of CSA. His resolute conclusion speaks volumes about the profound impact of this work on him.

Liz went further in dealing with the impact of the male CSA work on her: “I feel that at some point I will have to take a break from all of that and um just have some more light clients with like very boring issues (laughs)” (Liz 10:288). Liz reached a point where she identified needing a break and contemplated only working with clients with less challenging presentations.

3.3 Superordinate theme 3 - Taking Care of Self

The third super-ordinate theme is “Taking Care of Self”. The therapists’ accounts describe the importance of looking after their well-being whilst working with male CSA survivors. Their experiences reflected three broad areas of taking care of themselves. Firstly, the therapists found it essential that they received male CSA specialist professional support from their organisation and their supervisors. Secondly, they identified ways to protect themselves in the therapy room with their clients. Thirdly, they recognised the significance of work-life balance and utilising ways of taking both physical and mental breaks.

3.3.1 Subtheme 1 – Professional support.

The therapists identified a strong need to be supported when working with male survivors of CSA. This included supervisory support, support from their colleagues, organisation and having their training needs met. The common thread among the therapists’ experiences in terms of support (e.g. organisation, supervisor) was the significance of knowing the client group and understanding the specific issues of male CSA.

Lucy, Liz and Emily talked about the importance of good supervision; each highlighting different aspects of supervision. Lucy identified needing someone who understood the client group: "…good supervision. That's what you really need. Good supervision, who understands about this client group" (Lucy 10:274). Lucy needed to feel confident that her supervisor understood the work with male CSA survivors and its particular challenges. Her experience indicated that a supervisor without knowledge of male CSA would perhaps not have been appropriate in supporting her work.

For Liz, good supervision is: "where you can bring in your hatred or disgust for the client or […] or I feel burnt out" (Liz 16:454). Liz needed a supervisor, whom she could speak with freely, regardless of the nature of her thoughts and emotions; a judgment free environment where she could bring her strong and perhaps difficult emotions.

Emily also recognised the importance of having a supervisor to guide her. However, her experience was tainted by her struggle to find a supervisor willing to supervise work with male CSA survivors: "was really important, but we were both finding our way, I have to say. But at least we were, I was doing it with someone" (Emily 19:574). Emily acknowledged how crucial it was to have a supervisor, even though her supervisor was learning about this client group alongside Emily. Nevertheless, she was grateful not to be alone and to have someone to talk to about her work.

Being supported by the organisation they worked for was also recognised as important by the therapists. Liz's workplace required that the therapists had a minimum of 20 minutes break between therapy hours as opposed to the more conventional 10-minute break: They are very mindful of giving us the extra time to write notes, just to process, maybe have a cup of tea, move rooms, change, talk to, maybe have a chat about something else […] So important! (Liz 12:343)

Liz appreciated that her organisation was aware of the demanding nature of her work and provided the appropriate support and conditions for working with this client group. Liz listed several examples of ways how to use the extended break to reenergise without having to rush into the next session which was clearly deemed by the organisation as an unsafe practice; thus, highlighting the challenging nature of the work.

As a way of being supported in their work, the therapists also expressed the need for specialist training. Emily shared how not receiving specialist training to work with male CSA survivors impacted her work: “I think it did a lot. Um, you know the answers I am giving you now are after a lot of experience. […] it impacted hugely. I was very much um kind of working as I went along” **(**Emily 19:559). Reflecting on her practice, Emily felt that not being given male CSA specific training had a major effect on her work with this client group. Consequently, she had to learn through experience which appeared to be filled with great challenges, particularly as she did not feel that her professional training was sufficient for this work.

Paul’s experience resonated with Emily’s in that he deemed his psychology training insufficient in preparing him for the work with male CSA:

> He (patient with male CSA history) was a big part of why I chose to train (analytically) at the time that I did. Because working with him with only, only, with only my psychology training just got us into such a mess (Paul 23:662)

Paul’s felt lack of competence to work with a male CSA survivor after qualifying as a psychologist contributed to him pursuing a psychoanalytic training. He felt underqualified and unprepared to work with a male CSA survivor without further training.

3.3.2 Subtheme 2 – Managing the therapeutic encounter.

In addition to identifying a need to be professionally supported in their work with CSA survivors, the therapists also demonstrated a need to get in touch with their internal supervisor to manage the therapeutic encounter. Some of the therapists experienced feelings of discomfort in their work with their male clients which ranged from being cautious to feeling threatened and afraid of their clients' anger. The therapists found ways to manage their experiences, such as being transparent with their clients and understanding their clients' experiences.

Some therapists appeared to have felt threatened by their clients and felt that they needed to protect themselves. At times this was openly talked about and other times this was indicated by both the client's and the therapist's behaviour.

Paula explained that being transparent about her thoughts with her clients helped them to feel safe which assisted in regulating their emotions.

> So, if I am listening and I am being really clear about what's going on in my mind then they're less likely to (be violent) because they, they feel safe because I am saying what I am thinking and doing what I am saying, and I am listening to them. And you know validation, empathy, normalising - all that usually defuses it, an angry client, usually. (Paula 25:692)

Although Paula talked about her clients' safety, her experience gave the impression that perhaps she herself did not feel safe and her methods to regulate her clients' emotions were ways to keep herself safe too.

Similar to Paula, Liz also appeared to have felt threatened by her client:

> l'll go, actually I am ok with it, I am not scared of emotions, I am not scared of anger. Coz, I am not scared of anger because I am working in a very safe, contained environment you know, um and I understand it's not about me about, it's about a raging inner child (laughs), you know. (Liz 20:586)

Liz talked about not feeling scared of her client's anger. She felt reassured by the safety of her environment and her ability to make sense of her client's presentation. Although she expressed not feeling scared, her need to reassure herself gave the impression of some level of discomfort which became clearer as she used the idea of a blank screen rooted in psychodynamic theory to help her make sense of her client's anger directed at her: "They don't know anything about me, so it can't be personal. This is about somebody else um from their past" (Liz 19:560).

She needed to find an explanation that created a distance between her clients' anger and her which served as a protective shield. She needed to reassure herself that her clients' behaviour was not about her. Understanding her clients' emotions helped Liz to manage her own fear: "It can be tough but not too tough because I understand it (laughs)" (Liz 8:212).

Whilst Emily did not express feeling threatened by her clients, she expressed feeling cautious and perceiving her clients' caution:

> I tend to every so often reflect back to the client […] my awareness in the room of their caution or my caution and I'll share that so that they kind of know that I am being mindful of these, these possible struggles for both, for both client and for me. (Emily 6:159)

Emily described needing to be transparent with her clients and letting them know about what she experienced for herself and from her clients. Earlier in the interview,

Emily talked about a sense of betrayal her clients experienced towards women who abused them or contributed to their experiences of CSA: “they feel (pauses), whilst in the room, a betrayal and there is something about the woman not having been in a protective nurturing role that, that the woman has somehow betrayed her sex by doing this” (Emily 3:93). Emily explained that her client’s sense of betrayal was also present in the therapy room. This indicated that on some level Emily’s experience of her clients’ sense of betrayal might have contributed to the caution she described.

3.3.3 Subtheme 3 – Personal self-care.

Although, the therapists recognised that self-care was an important practice for all therapists, they felt that it was warranted even more when working with this client group. Their experiences appeared to be instigated by their previously reported challenges of this particular work. They identified different ways of looking after themselves, such as finding ways to switch off from the survivors’ stories, taking breaks, going on holiday and reducing their workload.

Some recognised the importance of switching off mentally and leaving the horror stories behind when leaving work: “when you’re hearing horrible um stories all the time, you do need to self-care um yeah and kind of leave it at work” (Lucy 7:185). Lucy felt she needed to counterbalance the impact of listening to her clients’ abusive stories and needed to switch off from work.

Some therapists talked about the importance of taking breaks and going on holiday; “having a break from work. Um, yeah I guess that’s kind of important self-care which would be the same I guess in any sort of counselling environment, but I do feel particularly here” (Lucy 17:485). Lucy recognised that breaks were imperative in any therapeutic work but felt that they were more important in working with male CSA

survivors which links back to the therapists' challenging experiences discussed earlier.

Similar to Lucy, Liz felt that breaks and holidays were very important in looking after herself. She described them as protective:

> I think what protects […] me doing my own self-care and going ok I need to have my own little break, or I need to have a you know a proper holiday. I think holidays and breaks are really important. (Liz 11:301)

Liz's way of describing her experience indicated that she felt she needed ways to protect herself from the effects of this work.

Some therapists found cutting down their hours was a way of looking after themselves. Liz did this when she started feeling the impact of the work on her wellbeing. "I've got four in [organisation's name] and I've dropped it down to three for a while um and I thought mm, that feels nice actually" (Liz 10:279). Liz described an uplifting feeling as she started noticing the benefit of having fewer clients as if it created an experience of being unburdened from a heavy load.

Similar to Liz, Lucy also felt the need to reduce her client hours. In Lucy's case, this happened as a consequence of a funding crisis that destabilised her organisation which had a knock-on effect on the therapists and resulted in additional pressure to remain stable for their clients.

> It was after the funding crisis was over and I've held it all together that it kind of hit me and then I was like: "I need to cut down my hours". […] It was a hard decision for me to cut down on my clients. I've never finished early with clients before. Um that was a really hard decision, but I need... I needed to. Um, so

> yeah, I guess that's another thing about self-care knowing what, what your capacity is. (Lucy 18:512)

It appeared that the funding crisis created an additional pressure and required an extra effort from Lucy to provide stability for her clients. She could manage it for a short time but once the crisis was over, she realised how much it took out of her.

Lucy seemed to struggle with the decision to reduce her client hours. It appeared to be in conflict with her work ethic which perhaps induced a sense of guilt in her. However, Lucy recognised that she reached her limit, and she needed to put herself first.

The therapists' difficulty to put their wellbeing first above their work was also echoed by Liz; "(self-care) It's really, really important. Yeah, and hard to do sometimes" (Liz: 28:814).

3.4 Superordinate theme 4 - Caring about the Clients

The fourth super-ordinate theme is "Caring about the Clients". The therapists became strongly emotionally tied to their clients. They felt protective of them, felt a need to shield them from harm and advocate on their behalf. The clients' vulnerability evoked maternal feelings in the therapists. They wanted to provide them with safety in the therapeutic room. However, creating a safe environment was also linked to the therapists' perceived threat of their clients.

3.4.1 Subtheme 1 - Feeling protective of the clients.

It became evident that the therapists felt deeply about their clients. They experienced a strong emotional connection towards them which manifested in feeling protective

of them, feeling maternal, feeling strongly about what was right or wrong for them and advocating on their behalf.

The therapists described feeling a strong emotional connection to their clients: “when I emailed you, I said this was dear to my heart um and you can probably, that's what the sighs are about” (Emily 8:243). Emily was deeply invested in the issue of male CSA. During the interview, she frequently sighed as she talked about her clients and her experiences of them. She explained that the sighing reflected her strong feelings about the issue of male CSA and the struggles her clients faced.

The therapists’ emotional connectedness to their clients manifested in feeling protective of them: “I really, really do connect with them. Really feel quite protective over them actually” (Liz 2:48). They connected with the child within their clients that was not protected, and they expressed a strong emotional reaction to their past and present circumstances.

Paula described:

> men could do with a healthy male role model um and they haven't had that, and you know they kind of at sea in the world really and they are...kind of lost. Lost boys I call them really, lost boys and they don't know which way's up and what really gets me you know that, that people weren't protected, that people were at a very young age really taken advantage, advantage of and yeah the men just yeah, it's rubbish. (Paula 16:425)

Paula expressed feeling passionate about her clients’ circumstances. She felt strongly about what was lacking in male survivors’ lives when they were growing up and the subsequent impact on them as adults. She was a witness to the consequences of their upbringings in the therapy room and experienced them as lost.

She described feeling struck by the fact that children were exposed to abusive experiences. This seemed to affect her deeply. She appeared angry with the fate these men were dealt.

Lucy also identified with feeling protective of her clients: “I feel quite um protective of them” (Lucy 2:50). This also manifested in her feeling that she needed to shield them from the chaos of the healthcare system cutting the funds of her service which affected the continuity of the therapeutic input: “I felt like I was having to hold the clients and protect them from this chaos” (Lucy 17:508).

The therapists’ protectiveness of their clients could perhaps be related to the wider effect of this work on them manifesting in increased sensitivity and hypervigilance as described earlier. Perhaps the therapists feel over-responsible for their clients’ well-being as a way of trying to cope with the increased sense of threat to the safety of vulnerable others.

The therapists also felt like they knew what was best for their clients and advocated against practices that they felt could be harmful to them: “it’s punitive to leave a client in silence I find a lot here, particularly in the initial stages in assessment and um, the first stages. So, um a lot of the work isn't in silence” (Paula 19:524). Paula empathised with her clients and believed that they would experience silence as painful and penal.

Paula expressed her strong views on the subject:

> This isn’t some kind of an airy fairy, weird therapy that you know I am going to lie on the couch and Freud’s gonna kind of make one, one, one, one intervention per session and I am going to be left in excruciating you know turmoil (chuckles) myself. (Paula 20:534)

Paula felt passionate about acting in her clients' best interest and stood strongly by what she believed to be helpful or harmful to them. However, Paula's description indicated that perhaps she herself might have experienced some discomfort with being in silence with her clients. In her initial quote about silence, Paula was very clearly talking about her clients, but in the second quote she moved onto referring to herself lying on Freud's couch and being in excruciating pain. Perhaps, it is uncomfortable to be in silence for both the therapist and the client which resonated with previous accounts of the therapists linking silence to their clients' CSA experiences where they were often told to be silent when abused or blackmailed to keep the abuse to themselves.

The therapists' protectiveness of their clients was also experienced through feeling maternal towards them: "the client really showing a very childlike part of them in the work and I think I just had responded, I really found it quite interesting, something um quite maternal in me had come out" (Lucy: 1:10). Seeing a childlike side to her client triggered maternal feelings in Lucy. Her reaction to her client was unexpected. She was surprised and intrigued by it.

Paula explained that her clients were often puzzled with the nature of the therapeutic relationship and she responded to this in the following way:

> Just go with it and if it works then you know great and the most important thing is that you get a relationship where you experience something of acceptance, something of care, something that you may have not experienced before. (Paula 14:387)

Paula talked about the positive experiences that she sensed her clients were unlikely to experience previously. She spoke of acceptance and care. Paula encouraged her clients to become open to a process where they could feel accepted and cared for.

This resembled the role of an intuitive, protective mother who was trying to guide her children to meet their needs. The presence of the maternal care was also evident in Lucy's reflections: "just really having to go with what um they need, teaching them, allowing them some kind of a self-regulation and respecting that" (Lucy 2:59).

These experiences were only captured in the female therapists which poses a question whether their maternal side indeed contributed to their experiences.

3.4.2 Subtheme 2 - Providing safety for the clients.

The therapists felt highly attuned to their clients' needs and felt strongly about creating a therapeutic space that was going to be experienced as safe by their clients. Whilst this would be a natural condition that perhaps therapists would aspire to achieve in the therapy room in general, safety appeared to have taken on a greater significance in the context of working with male CSA survivors which was attributed to the vulnerability of this population due to lack of societal support and understanding of the challenges they face.

"It's (therapist's experience of being trusted by her clients), well, it can be huge, it can be really hugely important" (Lucy 4:120). Lucy explained why she believed safety was so important: "…making them feel safe so that they can start to engage with the process (Lucy 6:166). She felt it was crucial for her clients to feel safe to participate actively in the therapeutic process. Paula also talked about developing trust with clients to create a safe place for them to learn to engage in a relationship "it's gently letting them begin to trust you, ... Um and (pauses) developing that trust, developing that safe place where they can test out a relationship" (Paula 17:462).

Due to a lack of support available to these clients outside of the therapy room, the therapists often found that the therapeutic space was the only safe haven for their clients. However, the therapists' strong wish to keep their clients safe may also

indicate an increased sense of responsibility when witnessing other systems failing to provide their clients with the much needed support: “I see clients who are very much in need of one a level of understanding from the criminal justice system itself um and also um in need of the, a safe place which I think of is therapy” (Emily 8:245). In her work, Emily witnessed her clients’ complex histories not being recognised and understood and she connected with their pain. She recognised their need for a safe place where they could be heard and understood and believed that therapy could provide this for them. Emily’s experience indicated the difficult position she was in. She was employed by an organisation within which her clients were placed. Inherently, she was part of a system that she felt was failing her clients, and she was trying to create a safe place for them in her therapy room which was situated within the same system and yet away from it.

Adam felt that men with CSA histories have suffered immensely and their experiences of CSA were truly horrific.

He described his way of creating a safe place for his clients where they could open up about the horrors of CSA.

> Men come with the most terrible stories of what’s been done to them. So, I try and meet them accepting of their story, hear their story, believe their story, um perhaps normalise the uniqueness of their story, to um ask them to share the story, so they don’t hold on to those feelings just in themselves but give them a safe place to talk about it. (Adam, 20:576)

Adam empathised with his clients’ abusive experiences as he became witness to the dreadful stories entering his therapy room. His acknowledgment of the level of darkness of the stories that men carry appears heartfelt yet indicates no surprise. Adam recognised all the fundamental issues of not being heard, believed and

accepted that could make the therapeutic process even more challenging for men. He wished for his clients to recognise the prevalence of their experiences and for them to feel safe to share about them.

The length of the therapy appeared to have played an important role in allowing the therapists to build trust with their clients and create a safe therapeutic space.

> the fact that he trusted me and he showed himself […] I think seeing that um that it was safe for him to show a part of him um and then for him to start doing that outside was just hugely important but that was a client I worked with for two years. (Lucy 4:123)

Lucy explained how building a trusting relationship with a client enabled him to become more open with her and made him feel safe to show different sides to him which extended into his life outside of therapy. Lucy emphasised the role of time in developing a trusting relationship and achieving this level of progress.

The length of therapy appeared to have facilitated safety in more than one way.

In Emily's clients' case, it was the set number of therapy sessions that provided the clients with a sense of safety:

> The person I work with in, I am gonna say, in some ways knows that that's a safety that this will only go on for so long and then it stops. And actually, a number of them talk about liking (pauses), appreciating the containment that it gives. (Emily 10:303)

The setting Emily worked in offered therapy for six months. In her experience, the clients found the duration of the therapy sessions and knowing that therapy would eventually end containing. The containment that the certainty of the ending provided

for her clients indicated how challenging the therapeutic process must have felt for them. Perhaps, Emily shared her clients' sense of containment.

The type of therapy used was identified by the therapists as another way of providing safety for their clients: "So, so the choice of, the choice of therapy for me is very much giving the person the space and safety to explore" (Emily 5:141).

Emily explained how her choice of the therapeutic style and approach linked to her clients feeling safe:

> one of the biggest things is actually building up a relationship um and a relationship of trust because someone who has been so abused as a child um and again because of my particular population usually in an institution of some kind um you know they sent to see a psychologist, um another person from another institution um and when they were sent for help before for whatever reason that was, they ended up abused. So, one has that in one's mind constantly um at the beginning. (Emily 5:143)

Emily described the importance of considering the potential impact of her role and her work environment on her client group who in many cases were abused in an institution by someone in a position of power. Therefore, in Emily's experience, trust is fundamental in working with male CSA survivors but also very difficult to establish. Consequently, the choice of the therapy, which in Emily's case was person-centred therapy, was guided by her efforts to create the optimum conditions for her clients to feel safe with her.

Chapter 4 – Discussion

4.1 Introduction

This study used IPA to explore therapists' experiences of working with male CSA survivors. Comparatively to female CSA, male CSA remains an under-researched area with only few studies exploring health professionals' work with this particular group. The existing research focused mostly on health professionals' attitudes and employed predominantly quantitative methods of enquiry, thus leaving in-depth exploration of therapists' experiences of working with male CSA survivors largely under-researched.

The aim of this chapter is to review and critically discuss the findings with reference to existing research presented in chapter One and expanding on the current knowledge to integrate new findings. This chapter begins with a brief summary of the findings. It then discusses the findings in relation to the existing research. This is followed by discussing the limitations of the study and by considering the implications of the findings for therapeutic practice, policy, training and supervision. It makes suggestions for future research and concludes with reflections on the research process and outcome.

4.2 Theme One - Impact of Societal Attitudes Towards Male CSA on the Therapists' Work

The three subthemes presented within the superordinate theme of "Impact of societal attitudes towards male CSA on the therapists' work" captured the powerful role societal perception of maleness and male CSA plays in male survivors' lives, in their treatment and the therapists' experiences of working with the survivors, thus creating a sense of a triadic presence in the therapeutic work.

In the current study, it became evident that prior to working with male CSA survivors, some of the therapists may have thought about males and the issue of male CSA in traditional stereotypical terms. This finding is consistent with the results of Gruenfeld et al. (2017) that therapists who have previously not worked with male survivors of CSA were prone to believing gender norms. In the current findings, the therapists' perceptions have shifted as they gained experience working with male CSA survivors and had the opportunity to witness different sides to their male clients in the therapy room. This appeared to have assisted the therapists in becoming more open and able to think about the realities of male CSA. This is in support of Paul and Paul (2014) who found that direct therapeutic experience with male CSA survivors benefitted therapists in becoming more effective in their work.

The current findings further revealed that the therapists also became witness to systemic denial of the issue of male CSA through their clients receiving insufficient support for the complexity of their presentation and facing minimisation and dismissal of their CSA experiences. These experiences were previously evidenced in Nelson (2009) and Rapsey et al. (2017) who found that male CSA/SA survivors face CSA related obstacles of social stigmatisation in different stages and areas of their life, including when seeking treatment. The effects of societal attitudes towards male CSA were not only evident in the clients' experiences as witnessed by their therapists but also became apparent in the therapists' parallel experiences of their clients' either directly in the therapeutic work or outside of the therapy room, e.g. through not being able to secure supervision or through the nature of their work being questioned and the severity of the impact of male CSA being dismissed. Although, no direct link to existing literature has been established about the impact of societal attitudes towards male CSA on the therapists, in a study conducted by Schauben and Frazier (1995) the therapy practitioners reported the most challenging aspect of their work with SA survivors was dealing with the unfair approaches of other systems, e.g. CSA survivors

receiving injustice at the hands of the criminal justice system, inadequate funding for therapy support and societal apathy about violence against women. As this study did not differentiate between female and male survivors in its reporting of their findings and it included clients with CSA and SA history, it remains unclear to which client work these experiences were attributed to. However, considering that this study was conducted 25 years ago and today the progress achieved in female CSA/SA research is comparatively greater than in male CSA/SA, it could be tentatively proposed that Schauben and Frazier's (1995) findings depict the complexity of the male survivors issues in the current climate the way they reflected the female survivors' issues 25 years ago. This is supported by Corbett's (2016) clinical work with male CSA survivors. In his experience, the justice system does not attribute significance to the negative impact CSA has on the survivors' lives which not only has legal implications, but it also has consequences for social and cultural attitudes. Nevertheless, the present findings offer a new contribution to the understanding of therapists' experiences of male CSA work by clearly highlighting the direct effects the societal attitudes towards male CSA have on their work. It could also be hypothesised that in the current study the therapists' parallel experiences of their clients enhanced their understanding of the impact of societal misconceptions on their clients' experiences and assisted them in distancing themselves from the stereotypical societal narratives of masculinity and male CSA as discussed earlier. The current study proposes that therapists' preconceptions about CSA are thought to be more evident in work with males than with females. This is supported by two strands of evidence. One, this does not appear to be a theme found in recent literature on female service users' experiences of therapy services (e.g. Chouliara et al., 2011). The opposite is true for male CSA survivors' experiences of healthcare professionals (e.g. Teram et al., 2006) and mental health service providers' views (e.g. Sivagurunathan et al., 2019) which indicate dismissive behaviours, perceptions and attitudes of service providers towards male CSA. Two, research which examined mental health practitioners'

perceptions of gender norms (e.g. Richey-Suttles & Remere, 1997) were overwhelmingly more likely to suspect CSA in female clients/patients.

Whilst in the current study witnessing and dealing with the systematic dismissal of male survivors' experiences might have had a positively transformative effect on the therapists' perceptions of maleness and male CSA and in turn on their practice, it also became an ever-present obstacle in the therapeutic work. It evoked feelings of helplessness in the therapists' ability to help their clients to come to terms with their trauma through the therapeutic work and through not being able to affect services' and society's reactions to their clients' issues. Although therapists' experiences of helplessness have been documented in research on VT (e.g. Chouliara et al., 2011), the studies looked at therapists' work with survivors of CSA in general as opposed to with males. Moreover, the sense of helplessness was evoked by listening to survivors' stories of sexual abuse as opposed to a consequence of societal airbrushing of male CSA experienced in therapy. Therefore, the therapists' experiences of helplessness, as described below, may contribute to understanding of the incapacitating impact of societal attitudes on the therapists' practices. Staub (1989) proposed that the sense of helplessness that stems from the therapists' inability to change the survivors' past or the state of events affecting their current lives challenges the therapists' identity of a helper.

4.3 Theme Two – The Challenging Nature of Male CSA Work

The theme "The challenging nature of male CSA work" captures the demanding nature of male CSA work described through the therapists' personal and professional challenges of working with this client group which also encapsulates the therapists' contrasting experiences of working with male CSA survivors.

The current findings suggest that the survivors' accounts of their abusive stories had a profound impact on the therapists. Although, an element of being used to hearing stories of sexual violence was evident in the therapists' accounts, the cumulative effect of listening to these stories appeared to have contributed to the negative impact on the therapists' personal lives. The cumulative effects of repeated exposure to traumatic stories is well supported by previous literature on VT (e.g. Pearlman & Saakvitne, 1995). It is in fact apparent from the current findings that the therapists' described experiences were in line with symptoms of VT (McCann & Pearlman, 1990). The therapists developed fear for their own and their children's safety, with changing perceptions of their immediate communities and their surroundings. These concrete fears appeared to have resulted in the therapists perceiving the world as more dangerous and becoming more vigilant. Some therapists reported distressing preoccupation with the subject of CSA. They also spoke about unusually intense experiences of countertransference which were perceived as overshadowing the therapists' lives. There was a clear appearance of an experience of violation of the therapists' personal lives as their work invaded and altered their perceptions and experiences of their world. These experiences are in line with the existing literature that reports high prevalence of VT in therapists working with CSA (e.g. Chouliara et al. 2009; Nen et al., 2011).

To the researcher's best knowledge, there is no existing literature on VT in practitioners working with male CSA survivors and as such the current findings are the only ones evidencing this phenomenon. The literature that is available as reviewed in chapter One (Chouliara et al., 2009; Nen et al., 2011; Van Deusen & Way, 2006) focused their research interests on practitioners' experiences of VT in relation to CSA work in general without specifying the gender of the survivors. The VT related findings discussed so far suggest highly intense and disruptive experiences interfering with the therapists' lives which based on the knowledge of the

existing literature appear to be perhaps more nuanced and intense in their quality. Nonetheless, without a comparison study any conclusions drawn could be highly assumptive.

However, the therapists in the present study were not only challenged by the effects of the traumatic stories on their lives, they also described experiencing professional challenges. The current study proposes that these professional challenges may provide additional support for the therapists' reports of the work with male CSA survivors being experienced as more challenging than with other client groups.

The female therapists described feeling fearful of their clients' anger and experienced their male clients as angrier than their female counterparts. The therapists described adopting different methods to deal with and potentially decrease the perceived threat experienced from their clients. These findings are very marginally consistent with the findings of Yarrow and Churchill (2009) who found that two of the thirty-five therapists expressed concerns about provoking abuse related anger in their male clients. Lab et al. (2000) also concurs the current findings as in this study mental health professionals provided the fear of the patients becoming angry or aggressive as one of the reasons for not enquiring about CSA. The mental health professionals' gender was not reported in this study, nor were the respondents' answers grouped based on professions. It remains unclear whether fear of clients' anger is more likely experienced by female therapists or whether this is just an occurrence specific to the therapists participating in the current study.

A question could be posed whether these male clients would have behaved the same way if they were seen by male therapists. The therapists reported that their clients often experienced women as betraying their female role of the nurturer and protector by being the abuser, taking part in the abuse, not preventing it or not believing the

survivors when they disclosed about the abuse. Therefore, one of the possible explanations for these findings is that in the transferential relationship towards the female therapists, the male clients displayed more anger towards the female therapists than they would have towards the male therapists. Alternatively, the male survivors' increased aggression could be explained by their intrinsic need to triumph their abuser.

The therapists also spoke about the intensity of their clients' experiences of shame and self-blame, fear of disclosing, not being believed about their abuse, and difficulty trusting and coming to terms with their abuse which the therapists not only described as more severe in their male clients than in female CSA survivors or other clients, but they also found them more problematic to address and shift in the therapeutic work. This is supported by Nelson (2009) who found that males shared many experiences with female survivors; however, they appeared to struggle more to trust and disclose and were considerably more susceptible to confusion over their sexuality and gender identity. Moreover, the current findings are also in line with Teram et al., (2006) who concur gender-specific differences in the male CSA survivors' perceptions and experiences of disclosure, shame, victimisation, and homophobia. On the other hand, Yarrow and Churchill (2009) found that 25% of their participants did not find the work with male CSA survivors different from any other clients on their caseload. While 37.5% of their participants found that supervision support was extremely important when working with male CSA survivors, with therapists expressing additional concerns over their ability to support their clients competently, and over their own vulnerability and suitability to work with this client group. Therefore, only a quarter of the practitioners found the work with male CSA survivors the same as working with other clients, whilst the majority expressed concerns similar to those in the current study. Therefore, it would be of interest to explore what made the experience different for those therapists who found the work the same and whether the findings would

yield the same outcomes with semi-structured interviews as they did with postal questionnaires utilised in this study.

From the current findings it also became apparent that as a result of the impact of the combination of the personal and professional challenges experienced by the therapists, the majority of them expressed a choice not to have too many male CSA survivors on their caseload. Some expressed a need to reduce their client hours and some even deliberated over not working with this client group at all. Only a tentative link could be established with previous research where therapists questioned their suitability to work with this client group (Yarrow & Churchill, 2009) or reported not feeling competent and confident (Gilmour, 2015; Lab et al., 2000). However, the therapists in the current study did not overtly express a concern over being unsuitable to work with male CSA survivors. Two therapists spoke about their lack of competence historically, but since then they have gained extensive experience and additional training.

Contrarily, the current findings indicate a need to limit male CSA workload due to a general overwhelming impact of the nature of the work on the therapists which indicates new contribution to the work with male CSA. Knight (1997) proposed that the survivors' symptoms and abuse characteristics may influence the therapists' reactions, indicating that the severity of the survivors' trauma is likely to shape the therapists' experiences. This supposition provides some support for the therapists' complex experiences and reactions of limiting their work. An alternative explanation could be that the varying degrees to which the therapists felt they needed to create a distance from male CSA work indicated the different levels of coping capacities as conceptualised by Harris' (1995) four phases of endeavouring to constructively manage the repercussions of working with traumatic material as detailed in chapter One.

The existing literature on CSA provides evidence for the demanding nature of this work. Schauben and Frazier (1995) indicated that therapists who had higher cases of SA survivors experienced higher levels of VT and PTSD symptoms. Moreover, VanDeusen and Way (2006) found that VT in therapists working with CSA survivors exceeded the average VT levels for mental health professionals, with Rothschild (2002) suggesting that CSA falls under the most severe, Type IIB (Rn) trauma. There is clear evidence for CSA/SA work to be more demanding and potentially having more negative effects on practitioners engaging in this work. However, the current findings point not only to CSA work but specifically to male CSA work exceeding the demands of working with other clients including female CSA/SA survivors. As the current research is the only one of its kind qualitatively exploring work with male CSA survivors, its findings highlight the need for more enquiries about the impact of male CSA work on therapists and their ability to cope with the demands of this work.

4.4 Theme Three - Taking Care of Self

The theme "Taking Care of Self" captures the therapists' recognition of the importance of support and utilisation of various tools to ensure their well-being when working with male CSA survivors. This theme incorporates the therapists' identified need for professional support, a need to use their skills of experienced practitioners to manage the therapeutic encounter with their clients and to attend to their personal self-care.

Previous research into trauma work emphasised the importance of self-care, social support, training and supervision (Etherington, 2002) which have been identified to reduce the risk of VT (Van Deusen & Way's, 2006). In light of the therapists' personal and professional challenges working with male CSA survivors, as discussed in detail in the second theme, the therapists spoke about needing support to manage their

client work. Similar findings are reported in Yarrow and Churchill (2009) where therapists recognised the importance of support and this was highlighted as part of a "professional concerns" theme. The authors' recommendations were that support with this client group is an essential element of the therapists' self-care. The current findings reflect the therapists' need for good supervision which meant being able to be fully open with someone about the difficult emotions the clients bring up in the therapist. It also meant having someone who knows the client group with all their complexities and specific presentation to ensure that they could be well supported when working with this client group. When supervision was not available, this had a major impact on the therapist's ability to know how to work with this client group. Historically, the therapists also felt that they needed specialist or additional training to feel more competent to work with the complex presentation of male CSA work. This is supported by Lab et al. (2000) who found that only quarter of the psychologists considered their training to be enough when enquiring about male clients' experiences of CSA. Day et al. (2003) also found that lack of CSA specific training resulted in mental health practitioners not feeling comfortable or competent working with clients with CSA history. Nelson's (2009) report highlighted the importance of training and confidence building in practitioners working with male survivors of CSA for them to be able to address the issue of CSA with their clients. The therapists in the current study also identified the need for organisational support which meant for the organisation to recognise the heaviness of this particular trauma work i.e. dealing with the effects of hearing about their clients' traumatic experiences on the therapists' personal lives; dealing with the difficulty of helping their clients to come to terms with their abuse and relinquish of the shame and responsibility that does not belong to them; and coping with the systemic misconceptions about male CSA as discussed in greater detail in the first two themes.

In order to remain stable for their clients amongst all the professional pressures, the therapists spoke about needing to feel grounded which was partly ensured by the organisation being stable not only for the clients but also for the therapists, through adapting the physical and the mental space for this specialist work and by recognising the male survivors' needs of taking longer to disclose; therefore, providing enough time to safely explore and work through their traumas. Short support time was also reported to be an issue in Smith, Dogaru, and Ellis's (2015) survey of CSA service users.

As discussed in the second theme, some of the therapists felt uncomfortable and even threatened in their work with male CSA survivors. Although, similar findings were reported by some of the therapy practitioners in Yarrow and Churchill (2009), the practitioners' way of coping with their experiences was not discussed. Nevertheless, the present findings suggest that the therapists used different ways to manage, e.g. they adapted their therapeutic style and ensured transparency and clear communication with their clients to reduce any triggers to display threatening behaviour. While others used supervision and training to understand the reason behind their clients' anger which made the therapist feel that the client's presentation was less personal; therefore, less threatening. These findings highlight the importance of professional support for the therapists working with their clients, including specialist training, supervision and hands on support during client hours.

Another way the therapists in the current study self-guarded themselves was by taking regular breaks and attempting to disconnect mentally from their clients after leaving their workplace. While the importance of self-care in trauma work is widely recognised and strongly emphasised, literature also shows that therapists tend to disregard it (Figley, 2002). This is distinct from the current findings which show that most therapists recognised the impact the work with male survivors had on them and

took steps to mitigate it. The distinction between the current and previous findings could be ascribed to the personal and professional challenges discussed earlier in this chapter.

4.5 Theme Four - Taking Care of Self

The theme “Caring about the Clients” captures the therapists’ strong emotional connection to their clients. They felt protective of them and they wanted to provide them with safety. The therapists’ need to protect their clients and experience maternal feelings towards them was understood as a reaction to witnessing the childlike side of the men in the therapy room. The therapists also listened to the unspeakable trauma that tainted the men's development which perhaps helped the therapists to connect with the boys in them that they heard about in these stories. As described in the first theme, the therapists also gained direct experience of how society’s different systems position themselves towards the subject of male CSA which continue to place the male survivors in a vulnerable position with their needs being neglected. Feelings of sadness, anger and horror experienced by therapy practitioners at their clients’ CSA have been reported in previous literature (e.g. Knight, 1997). However, feeling overprotective have only been found to be reported in work with children with sexual abuse experiences (Nen et al., 2011). Considering the current findings, it is possible that the therapists as professionals in position of power, in a culture where male CSA is denied, transfer much of the responsibility for their clients’ wellbeing on themselves and this may also evoke feelings of societal guilt in them. This constitutes an experience of being bound to help, protect and save, while struggling to bear the horrors of male CSA. Alternatively, according to Valent (1995) the clients’ emotions and behaviour may evoke a complementary survivor strategy in the therapists, e.g. the client’s feelings of helplessness or anger for being betrayed by a woman may evoke care and responsibility or sense of guilt in the therapist and prompt the therapist into a rescuing response. Additionally, as discussed in the second theme, the

therapists themselves experienced feelings of vulnerability not only in their sessions with their clients but also as a result of listening to the survivors' stories which affected their sense of safety, safety of their loved ones and their experience of the world around them. Perhaps, the therapists' feelings of protectiveness towards their clients was a way of trying to cope with theirs and their loved ones' increased sense of danger.

The current findings also reflect the therapists' strong need to provide their clients with a safe therapeutic space. Although creating a safe space is a core requirement in therapy, it appeared to have taken on a greater significance with this particular client group. Similarly, to the therapists' experiences of wishing to protect their clients, the therapists may have felt compelled to provide their clients with experiences that they were deprived of in their childhood and which they may not have been able to create in their adult lives either e.g. for being in the prison system. The professional challenges the therapists experienced in terms of the male clients finding it more difficult to disclose and to be seen vulnerable also prompted the therapists to take extra care. Additionally, as discussed in the second and third theme, due to some of the therapists feeling threatened by their clients, the therapists became more vigilant in their approach which affected the dynamics in the therapeutic relationship.

4.6 Strengths and Limitations

To the researcher's best knowledge, this is the first UK-based study that carried out an in-depth exploration of therapists' experiences of working with male CSA survivors. The relatively small sample size of 6 participants enabled the exploration of each therapist's in-depth accounts of her or his experiences. The participants were highly experienced therapists with an average of twelve years of post-qualification experience and nine years of experience working with CSA survivors. Nevertheless, this study also had its limitations that should be considered next.

First, the sample was composed entirely of Caucasian participants. This restricted cultural and ethnic/racial diversity. To broaden our understanding of therapists' experiences of working with male CSA survivors, future studies should endeavour to recruit a more culturally and ethnically/racially diverse group of therapists.

Second, member checking, where participants provide feedback on results to improve the accuracy of their accounts, was not employed. On one hand, member checking could have increased the validity of the research. On the other hand, this could have interfered with findings that would have not been explicitly communicated by the participants but would have become apparent through their implicit accounts of their experiences which they themselves would have not had readily access to. Therefore, member checking could have led to exclusion of such information; thus, affecting the authenticity of the analysis.

Third, my preferred therapeutic stance influenced my approach to the analytic process. Therefore, my interpretations of the therapists' experiences were, at times, psychodynamically framed. This resulted in me moving away from their experiences. My supervisors' feedback and my reflection on my position enabled me to become more aware of my subjectivity. This has allowed me to move away from my preferred way of working as a trainee counselling psychologist and be more in touch with my role of a phenomenological researcher who was interested in getting close to her participants' experiences.

Fourth, what has become apparent during the process of analysis and grouping of themes is that despite the attention to separating different categories, the therapists' responses could often be organised into several intersecting categories. This was also found by Gruenfeld et al. (2017) who explained that qualitative data might be resistant to distinct categorisations. However, the intersecting nature of the categories

also reflects the therapists' complex and nuanced experiences which overlap and influence each other and reflect their genuineness.

Fifth, the data of the current study contained a substantial amount of information on the therapists' perceptions of the male CSA survivors' issues and difficulties which they not always linked to their own experiences or meaning-making processes. In hindsight, I could have either rephrased some of the interview questions to make the research questions less ambiguous or I could have posed more follow up questions during the interviews to link the therapists' experiences of their clients to their own. On reflection, I wondered whether this in itself was indicative of a distance created between them and their clients and whether my reticence to explore these links or unconscious steering away from their own experiences was also evident in my approach.

Sixth, following on from the previous point, single interviews were possibly another limitation of this study. Follow up sessions with the participants might have provided an opportunity for the participants to reflect on their initial contribution and prompted more in-depth engagement with the subject matter and opportunity to discuss any thoughts that the initial engagement would have triggered for them. Potentially, it would have assisted me in similar ways, allowing me to reflect on the interviews and have the opportunity to ask follow-up questions. Meeting the participants for the second time would have deepened the interviewer-interviewee relationship and would have potentially yielded a better rapport and trust.

4.7 Implications for Counselling Psychology Practice

This study aimed to contribute to an underexplored research area that affects therapists' practices, their own and the male CSA survivors' wellbeing. Qualified counselling psychologists, therapy practitioners in general and those in training would

benefit from gaining insight into their colleagues' experiences, challenges of working with male survivors of CSA and the meanings they have made from working with this client group.

Although reflective practice plays a significant part in the counselling psychologists' roles (BPS Practice Guidelines), the current findings indicate that there is even larger emphasis on reflective practice when working with male CSA. As the subject of male CSA continues to be largely stigmatised, therapists are just as likely to be influenced by societal attitudes towards male CSA as is the rest of the population. This is evident in the subtheme "Therapists attitudes and perceptions of male CSA" which reflects a phenomenon also supported by previous research (e.g. Holmes et al., 1997; Holmes & Offen, 1996; Richey-Suttles & Remere, 1997) that therapists have a tendency to hold the same societal beliefs as the rest of the population and through experience with male survivors of CSA and specialist training these beliefs can shift to the benefit of their work with their client group. Therapists must be self-aware and ready to continuously engage in a self-reflective practice about the stereotypes they may hold, about their preconceptions and biases, and the societal influences on their own views of men, masculinity and gender roles, and how these can impact their work with their clients.

A related key finding is that the societal reluctance to acknowledge male CSA and provide the survivors with the appropriate support impacts the therapeutic process and outcome as captured in the theme "Impact of societal attitudes towards male CSA on the therapists' work" and also evidenced in the existing literature (e.g. Corbett, 2016; Holmes et al., 1997; Holmes & Offen, 1996; Richey-Suttles & Remere, 1997). Due to lack of recognition of their victimisation, the survivors struggle to come to terms with their abusive experiences. Similarly, lack of interdisciplinary co-operation in supporting male CSA survivors and recognising the impact of abuse on

the survivors' lives can have a negative impact on the therapists' work with their clients.

The implications of these findings are that therapists need to have understanding of trauma and specifically of CSA, have awareness of males being just as vulnerable to CSA as females and have knowledge and awareness of the issues that these males are likely to face with regards to the additional obstacles of disclosing about CSA and seeking help, fear of and actual disbelief of their CSA, being treated as a perpetrator, struggling to talk about their victimising experiences or perceiving them as that. Therapists need to be alert to potential history of CSA, have understanding of the increased likelihood of comorbid presentations, recognise CSA when it is present, and manage disclosures and enquiries competently. Therapists must be aware of the frequently complex backgrounds of male CSA survivors and multi-agency involvement in their care (e.g. social workers, police, justice system) which may not always be optimal for the survivors' wellbeing and can have a negative impact on the therapeutic work.

Another important implication is the need for self-care. The current findings suggest that due to the complexity of the issue of male CSA and the challenges this poses for the therapeutic work including working with highly traumatic material can have negative consequences for the therapists' professional and personal lives as highlighted in the second theme "The challenging nature of male CSA work". Consequently, as captured in the theme "Taking care of self", the therapists identified a need to be supported by their supervisors, organisation and colleagues who all understand the particular challenges therapists face working with this specialist client group; therefore, are able to provide them with stability and a safe, supportive environment. The therapists also recognised the need to take care of themselves by taking regular breaks. The implications of these findings are for therapists to ensure

that they work in an organisation and are supervised by therapists who have the necessary understanding of male CSA and are able to provide therapists with the appropriate holding environment. The therapists should not underestimate the accumulative effects of hearing traumatic stories and should prioritise effective self-care practices as preventative measures to reduce the risk of VT. This is supported by Viviani (2011) who found that practitioners who have had over 20 years of experience with CSA adopted multiple coping strategies to safeguard themselves from VT, including engaging in reflective practice, supervision, monitoring for countertransference, focusing on the quality of their personal relationships and lives.

The previous research (e.g. Holmes et al., 1997; Holmes & Offen, 1996; Richey-Suttles & Remere, 1997) suggests that professionals working with male CSA survivors may struggle with limitations in knowledge and skills in the area of male CSA and are likely to be emotionally challenged by the work. Based on the current findings about the therapists' experiences evidenced across all themes but in particular in theme two "The challenging nature of male CSA work" and four "Caring about the clients", the implications for wider clinical practice are for therapists to work at the clients' pace which with male CSA survivors may likely be slower and take longer as indicated by therapists' experiences. This is also in line with previous research about male survivors taking considerably longer to disclose (Gagnier & Collin-Vézina, 2016). Although, the therapists in the present study did not unilaterally express preference for one therapeutic modality over another, the overarching experience was to create a therapeutic environment that was perceived to be safe by the clients. Transparency, clarity about the nature of the therapeutic work, open and clear communication of the therapists' thoughts, acknowledgment of the power dynamics and normalisation of the sexual abuse among males were all identified as crucial in establishing a safe space. Almost all therapists found drawing on psychoanalytic schools of thought beneficial in understanding the therapeutic

dynamic and the strong emotional encounters experienced by the therapists and their clients. Nevertheless, the majority of the therapists used the conditions of person-centred therapy to guide their engagement with their clients. The implications of these findings are for the therapists to be mindful of the client group they work with and the particular issues male CSA survivors present with which emphasise the importance of safety with these clients and guides their approach in working with them.

4.8 Implications for the Researcher's Future Clinical Practice

On the basis of the findings, it would be very important for therapy practitioners to know the scope of their practice based on their knowledge, experience and skillset when working with male CSA survivors. Therefore, I would engage in further training and professional development to ensure robustness of clinical knowledge and understanding of work with male CSA. I would engage in reflective practice exploring my own relationship to men, masculinity, CSA and gender stereotypes. It appears that taking a systemic approach to ensuring the therapy practitioners' well-being may contribute significantly towards good practice. Hence, I would seek not only a strong organisational and supervisory support in working with this client group, but I would also focus on maintaining a healthy work-life balance whilst attending personal therapy. Focus on professional readiness and personal well-being are fundamental when working with male CSA survivors as management of vicarious self-states and questioning of own competencies have also been evidenced in counselling psychology trainees working with CSA survivors (Gilmour, 2015). Similarly to the therapists interviewed, I would use my knowledge of psychoanalytic theory to inform and guide my understanding of the therapeutic dynamic but would likely use an integrative approach centred around the client's needs. I would focus on building a trusting therapeutic relationship which would include addressing the power dynamic in the therapy room and would aim to emphasise the client being the expert of his own experience and the therapist merely offering her support in making sense of his

experience at a pace that the client is comfortable with. This is in line with previous findings, whereas e.g. Moriarty (2017) found that the therapists' knowledge and experience in the area of male CSA was most appreciated when it was accompanied by a non-judgemental and understanding attitude and when the power in the therapeutic relationship was distributed equally.

4.9 Implications for Policy

The current findings may have some implications at the policy level. It is evident that the issue of male CSA is a multi-layered one, not only affecting the survivors themselves but also those aiming to support them. This has been echoed by the therapists' experiences.

For change to happen at a societal level, policy makers need to demonstrate greater presence and interest in the issue of male CSA. Even large-scale independent inquiries such as "The impacts of child sexual abuse: A rapid evidence assessment" report a crucial evidence gap of the impact of CSA on male survivors when reviewing evidence from 136 studies with only 11 of those focusing on male survivors. There is a strong need for independent enquiries and research into male CSA as opposed to including them under the umbrella of CSA which automatically leads to underrepresentation and overlooking of the importance and urgency of dealing with the issue of male CSA.

Moreover, policies specifically directed at raising the issue of male CSA and meeting the survivors' needs would contribute towards raising awareness of this issue. In line with increasing awareness, allocation of funds is needed for increasing access to training on male CSA and trauma-related issues across number of governmental agencies which are likely to provide service to male CSA survivors. The therapists' experiences indicate lack of understanding of the issue of male CSA in the criminal

justice system, social work and a number of other governmental sectors which contributes to marginalisation and mistreatment of the survivors.

Additional funding is required for setting up specialist male CSA services. Limited number of services specialising in male CSA became evident at the recruitment stage of the research process. Some services, such as rape crisis centres have now started opening their doors to male clients as well. Although evidently the percentage of male clients remains insignificant in comparison to female survivors and contrary to the frequently held belief the small male representation is not reflective of the prevalence of male CSA but rather of the limitations of service provision in catering to male CSA survivors.

Moreover, the current study strongly suggests that services that provide support to male survivors of CSA require stability and regular, uninterrupted funding as any destabilisation at an organisational level can have a massive direct negative impact on the therapists' work, wellbeing and that of their clients.

4.10 Implications for Training

The current findings show a strong need for specialist male CSA training. This is particularly highlighted by the subtheme "Professional support" which talks about how some of the therapists who trained as psychologists felt that their training did not prepare them for the work with male CSA survivors. They felt underqualified to work with this client group which had a significant impact on their practice and in one case it led to further professional training. Most therapists, even those that did not explicitly express feeling under-qualified, questioned their ability to work with some of the male CSA survivors as expressed by the therapists in the subtheme "Professional challenges", and this concern was extended to the whole of the therapeutic profession as described, for instance, by Paul in the subtheme "Therapists' sense of

helplessness". These findings are alarming, and they stress the need for in-depth training on the complex subject of male CSA at a qualifying training level. This would not only have implications on the therapists' readiness to work with male CSA survivors when these clients present to therapy but understanding of the complexity of this societal issue would feed into their day to day lives which would encourage awareness around them. In the current study, at the time of the interviews, all therapists bar one worked in specialist services or specifically with male survivors of CSA which has eliminated the issue of not being aware of their clients' history of CSA. However, in other services or private practices, they would not necessarily be aware of their clients' history if they did not enquire or the client did not disclose about it. Therefore, training providers should also focus on increasing trainee therapists' skillsets and competences to enquire about CSA history alongside being able to work with it.

4.11 Implications for Supervision

The findings of the current study indicated supervision to be of great importance in therapists managing their work with male survivors of CSA. Therapists working with this client group require supervisors who themselves are knowledgeable, experienced and skilled in the area of male CSA. They must be able to provide their supervisees with a strong holding space where the therapists can process the effects of their work on them and their clients safely. The risk of VT in therapists working with male CSA is significant, and the right supervision can mitigate these risks.

4.12 Suggestions for Future Research

Male CSA and particularly therapists' experiences of working with this client group remains a greatly under-researched area. To the researcher's knowledge, the current study is the first effort to carry out an in-depth exploration into therapists' experiences

of working with male survivors of CSA. The only other identified research was carried out by Yarrow and Churchill (2009) who endeavoured to explore therapists' experiences of working with male survivors of CSA. However, it employed questionnaires which limited the depth and richness of the data. Therefore, there are many avenues that could be taken to gain a greater understanding of this complex issue to contribute towards increased awareness and shift in social consciousness. The themes that were identified in the current study reflect significant aspects of therapists' experiences that therefore warrant further exploration, such as the challenges of working with male survivors of CSA, including working with clients' anger, disclosure, duration of therapy and pace of the therapeutic process. Moreover, these particular issues have been identified to be fundamentally different for male survivors of CSA in comparison to their female counterparts. If male survivors experience and process their victimisation differently to female survivors and therapists are identifying challenges in getting their male clients to connect with their experiences, perhaps a different approach is required. Therefore, this may also indicate a need for exploration of gender specific work with male CSA survivors.

During the current research process, it also transpired that there is seemingly no research exploring vicarious traumatisation in therapists working with male CSA survivors or for that matter comparison studies of VT in therapists working with male versus female CSA survivors. Therefore, there is a clear gap in the literature; thus, a lack of understanding of VT in therapists working with male CSA survivors. The subtheme "Professional challenges" suggests that therapists often refer to their male clients as one of or the most difficult clients they have worked with. Many of the challenges identified were specific to male survivors of CSA. Therefore, it is plausible to suggest that the impact on therapists will also be different and may manifest differently in male and female therapists. Therefore, the implication of such research could potentially be significant in raising awareness of particular triggering factors that

could be gender-specific, in developing appropriate preventative methods, coping strategies and remediation of VT.

4.13 Reflexivity

In the process of conducting this research, I was aware of my position as a researcher and a trainee counselling psychologist. In agreement with my conceptual constructionist position and IPA's double hermeneutic stance, I experienced the process of co-creating at every stage of the research. It was my part in this process of co-creation that, at times, made me uneasy and uncertain. I questioned my influence on the interview process, analysis, interpretation of the data and discussion of my findings. I was afraid of offending the therapists with my interpretations of their experiences and not doing justice to them. I was aware that most of the participants came forward because they felt passionate about the subject of male CSA and their clients. They were acutely aware of the issues surrounding male CSA as they were experiencing these directly in their work, often having a significant impact on their sense of identity and their world view. They were eager to share their experiences with the hope of the world taking notice and help them carry the weight of this huge societal problem.

At the initial stage of the data analysis, in listening to the therapists' experiences and transcribing the interviews, I also found myself becoming passionate. At times, when I sensed a therapist feeling lost and unable to express her awareness of her own processes, I found myself becoming protective of her clients. I found this to be a curious reaction on my part. I thought that my reaction was partly the transference of my sense of incompetence onto the therapist. However, I also felt as if I became aligned with the participants' experiences of needing to protect their clients.

I also felt connected to the participants as they negotiated their complex experiences of working with this client group and perhaps my witnessing of this process manifested in my own experience of forming the themes and subthemes as they emerged through the interpretative style of phenomenological engagement with the therapists' accounts. A blurring of boundaries was not only evident in the therapists' experiences but also in the overlap of themes in the analysis. I recognised my desire to keep the professional and personal aspects of the therapists' experiences separate as if wishing to support them with instilling boundaries between different domains of their lives and protect them or perhaps defend against the overwhelming, complex and often all-consuming nature of the issue of male CSA.

This research not only contributed to my growth as a researcher, but it was also invaluable in broadening my perspective as a therapist and enhancing my reflexive practice. The complexity of the subject of male CSA and the systemic upholding of this societal issue brought for me into focus the challenges the therapists and their clients face. Moreover, it helped me to become more aware of the intricate nature of each individual's experiences and how my capacity to be open to the complexity of my participants' or clients' experiences impacts the mutual process we engage in and its outcome.

4.14 Conclusion

The present study aimed to explore the under-researched area of therapists' experiences of working with male survivors of CSA. Employing IPA as its methodology, this study has explored in depth the therapists' experiences and meaning-making processes of working with male survivors of CSA. I propose that the therapists' experiences are intricately intertwined with the socio-cultural implications of masculinity and the society's relationship to victimisation of males. The therapists' experiences of their work with male survivors of CSA reveal a complex and

challenging relationship to their clients and the issue of male CSA with deeply rich and seemingly contrasting feelings and perceptions which have lasting implications on therapists' personal and professional lives. It also uncovers the unresolved tension between a desire to help, protect and save their clients from the horrors of their past and a need to create a safe distance from them to keep themselves safe and protected from the toxic fumes of CSA. The therapists need to find a balance between working with male survivors of CSA and engaging in other work. Male CSA informed support, supervisory and organisational holding along with good self-care and reflective practices are paramount in maintaining the therapists' well-being and being able to support their clients. More research is warranted in this area to understand the specific challenges, their impact and best practices to encourage change on a practice, training and policy level and encourage greater awareness and change in social consciousness.

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The Appendices

Appendix 1: Research Flyer

Therapists' experiences of working with male clients with a history of childhood sexual abuse - implications for counselling psychology practice: An Interpretative Phenomenological Analysis

Dear Therapist,
I am a Trainee Counselling Psychologist at the University of Roehampton, carrying out research into therapists' experiences of working with male clients with a history of Childhood Sexual Abuse (CSA).

The aim of my research is to contribute to:

- Slowly growing evidence, knowledge and understanding of the complexity of the subject of male CSA
- Shift in social consciousness and acceptance of the male children/adolescents' vulnerability and susceptibility to sexual abuse
- Understanding of socio-cultural attitudes to children, sexuality and gender
- Practitioners' training provision
- Development of professional practices of trainees and qualified practitioners
- Availability and attainability of support for male clients with CSA history

I am interested to explore the following questions with you:

- What is your experience of working with male survivors of childhood sexual abuse?
- What effect has this work had on your meaning making process or your professional practice?

If you are a therapist with the following characteristics, I would be delighted to hear from you:

- A qualified therapist (Counsellor, Counselling Psychologist, Psychotherapist)
- Trained in the UK
- As a qualified therapist, you have worked with at least two male clients with a history of CSA, with each for a minimum of six sessions

Following your expression of interest, I would provide you with more information about this research in the form of an information sheet and an interview guide and would be more than happy to answer any questions you may have.

The place and time of the interview would be agreed depending on your preference. The interviews will be audio recorded. The interview process should last about an hour to an hour

and a half (but may be shorter). Interviews will be confidential and interviewees will remain anonymous.

I look forward to hearing from you.

Marta Chromekova
Trainee Counselling Psychologist
Email: chromekm@roehampton.ac.uk

Department of Psychology
University of Roehampton

Appendix 2: Letter to Service Manager

Dear Service Manager,

I am a Trainee Counselling Psychologist at the University of Roehampton, undertaking research into therapists' experiences of working with male clients with a history of Childhood Sexual Abuse (CSA).

I would like to interview qualified therapists (counsellors, psychotherapists, counselling psychologists) about their experiences of working with male clients with history of CSA. I wonder if it would be possible to contact therapists at your service to establish whether they would be interested in participating in this research.

The aim of my research is to contribute to:

- The slowly growing evidence, knowledge and understanding of the complexity of the subject of male CSA
- A shift in social consciousness and acceptance of the male children/adolescents' vulnerability and susceptibility to sexual abuse
- The understanding of socio-cultural attitudes to children, sexuality and gender
- Practitioners' training provision
- The development of professional practices of training and qualified practitioners
- The availability and attainability of support for male clients with CSA history

Therapists' participation would involve an audio recorded interview and debrief session lasting up to an hour and a half. Depending on your and the practitioner's preference, the interview would take place within the service they work at, the University of Roehampton, their private practice or their home. Should it not be possible to conduct the interview in person, the therapists will be invited to participate in a Skype interview. Interviews will be confidential within the confines of the research project, and participants will remain anonymous in the write up of this research and in any subsequent publications or presentations. In the case that a disclosure of risk to self or another is made, confidentiality would have to be breached in accordance with safeguarding protocols.

Should therapists express interest in this research, they would receive an information sheet explaining more about the research and how to contact the researcher. Therapists identified as suitable and willing to participate in this research would be provided with an information sheet, and given the opportunity to discuss this with the researcher prior to interview.

This project has been approved under the procedures of the University of Roehampton's Ethics Committee. I would be very happy to offer any more information if required.

Please find attached a flyer with information about the research and recruitment criteria. I would be grateful if you could forward this to therapists working at your service or anyone able to assist and place it on your notice board if you feel this would be appropriate. I would also be very happy to come along and provide more information about my research.

I look forward to hearing from you.

Yours sincerely,

Marta Chromekova
Trainee Counselling Psychologist
University of Roehampton
Email: chromekm@roehampton.ac.uk

Appendix 3: Demographics Form

University of Roehampton London

Demographics form

Thank you for agreeing to take part in this research.
Please fill in the following information:

1. Sex:
☐ Male
☐ Female
☐ Transgender
☐ Other (please give details): **……**
☐ Prefer not to say

2. Age group:
☐ 18 - 29
☐ 30 - 49
☐ 50 – 64
☐ 65 and older
☐ Prefer not to say

3. Which is your ethnic group?
☐ White British
☐ Other White background, please describe:
……
☐ Mixed/Multiple ethnic groups
☐ Asian/Asian British
☐ Black African/Caribbean/Black British
☐ Other ethnic background, please describe:
……
☐ Prefer not to say

Do you consider yourself to have a disability?
☐ No

☐ Yes, I have a physical disability
☐ Yes, I have a sensory disability
☐ Yes, I have learning difficulties
☐ Prefer not to say

Please tick the relevant organisation you are registered with:
☐ HCPC Registered Counselling Psychologist
☐ BACP Accredited
☐ BACP Registered
☐ BPC Registered
☐ UKCP Registered

Please state:
1. Number of years of experience post-qualification:
……...
2. Name of Counselling/Psychotherapy training organisation:
……...
3. Theoretical Orientation
……...
4. Number of years of working with adults with CSA
……...
5. Number of adult clients with CSA history worked with (If not remembered, please state and give an approximate number)
……...
6. Number of adult <u>male</u> clients with CSA history worked with (If not remembered, please state and give an approximate number)
……...

Appendix 4: Interview Guide

Interview Guide

Introduction and space for questions

Q1: Can you tell me how you came to work with CSA clients?

Q2: What is your experience of working with male clients with CSA?

Q3: What is your experience of working with male clients with a history of CSA as a therapist of the same/opposite sex?

Q5: What are the challenges of working with male clients with a CSA history?

Q6: Can you think of a time when you felt challenged?

Q7: How do you make sense of these challenges?

Q8: Have you experienced any changes in your work with male CSA in comparison to when you initially started working with them?

Q9: Do you recognise any changes within yourself related to your individual meaning making process with male survivors of CSA since the beginning of your work with this client group?

Q10: Is there anything else that you would like to say?

Appendix 5: Lone Working Policy

UNIVERSITY OF ROEHAMPTON
LONE WORKING POLICY

Originated by Health & Safety Manager:	February 2010
Impact Assessment:	5 May 2010
Recommended by Senate:	26 May 2010
Approved by Council:	28 June 2010 11 March 2013
Review Date:	June 2015

Lone Working Policy

1. Introduction

This Policy sets out the way in which the University of Roehampton will deal with and manage the risks associated with lone working. The policy will be used to establish standards and a commitment to safety and therefore should be used to brief staff, as a reference document and the guideline to assess all relevant activities.

This policy forms part of the general health and safety policy documentation intended for use by directors, managers and staff and specifically by line managers responsible for staff who may work on their own.

This policy deals with employees who may work by themselves on or off campus or who work outside normal working hours on campus. Also, any students undertaking fieldwork, or practical/experimental projects without direct supervision and who are exposed to a significant risk of the hazards associated with lone working.

The head of health and safety provides competent support and manages a professional team to lead on all safety and health matters.

2. Legislation

There is no specific legislation on lone working. The general duty on employers to ensure the health and safety of employees, so far as is reasonably practicable under the Health and Safety at Work etc. Act 1974 (HASAWA) will apply.

Where working alone is identified in the workplace The Management of Health and Safety at Work Regulations 1999 (MHSWR) require employers to assess the associated risks and put in place any necessary control measures to ensure the safety of employees working on their own.

Although there is no overall prohibition on working alone there are some circumstances when there is a legal requirement for at least two people to be involved in the work e.g. work at or near live electrical cables Where lone working is identified the risk must be assessed and suitable risk management applied.

Key Legislation

Health and Safety at Work etc. Act 1974
Management of Health and Safety at work Regulations 1999
Corporate Manslaughter and Corporate Homicide Act 2007
Safety Representatives and Safety Committees Regulations 1977
The Health and Safety (Consultation with Employees) Regulations 1996
Regulatory Reform (Fire Safety) Order 2005
The Reporting of Injuries, Diseases and dangerous Occurrences Regulations 1995 (RIDDOR) Control of Substances Hazardous to Health (COSHH) Regulations 2002

3. Aims and Objectives

Aims

The aim of this policy is to ensure, so far as is reasonably practicable, that employees and students who work alone are not exposed to risks to their health

and safety and outline the steps to reduce and improve personal safety to employees and students who may carry out work alone.

Objectives

The objectives of this policy are to ensure:

Lone workers are identified

Risks inherent in lone worker situations are assessed and suitable precautionary measures taken. There is a local safe system of work which:

- Records the whereabouts of lone workers
- Tracks the movement of lone workers
- Follows an agreed system for locating employees who deviate from their expected movement pattern
- Identifies when lone working is no longer appropriate

4. Application

This policy applies to all employees, including temporary and contract workers or who are provided through an agency, and to students who are undertaking any fieldwork or practical/experimental projects during their academic programme without direct supervision.

It is not intended to apply to employees who work in an office on their own during normal working hours, unless their working alone presents a significant risk, it is also not intended to apply to students residing in halls of residence.

All departments are required to have in place local arrangements that comply with this policy.

5. Communication

It is important that all line managers ensure that this policy is communicated effectively to all their employees, and that all academic supervisors of students to whom this policy applies ensure that they communicate this policy effectively to them also.

6. Definitions

A lone worker can be anyone who works by themselves. A lone worker, for the purpose of this guidance, is defined as a member of staff or student who, for significant periods of their working or research time, is engaged in activities which places them in a situation without direct contact with other staff/students, or without direct supervision, during an activity that places that person at significant risk of exposure to a hazard or number of hazards.

All lone working activities outside of normal working hours must be notified to security by the person concerned. This is particularly important in the interests of personal safety and building security.

Normal working hours are as defined in individual employee contracts and may vary depending upon the role. Core working hours for the University can be taken as falling between 0800 and 1800hrs on weekdays.

Out of hours is anytime outside of the normal working hours for the University, including weekends and public holidays.

Hazardous areas are areas where an employee or student, may be exposed to hazards that are considered greater than those normally encountered within working environments such as offices or teaching spaces. These may include, for example, field work, laboratories or workshops.

A hazardous task is a task where the hazards encountered within the task are considered to be greater than normal e.g. working at height, working with electricity etc

A permit to work system is used within the property and facilities management department to control the works and activities carried out within the department

7. Categories of Work

The level of risk will be determined from completing the risk assessment.

Low risk activities

Should only be undertaken by persons authorised to do so by their line manager or supervisor who conducted the risk assessment with the employee. Work falling into this category is deemed to be safe to be undertaken by lone workers (e.g. general office work during core hours, employee carrying out general maintenance activities)

Medium risk activities

Should only be undertaken if there is at least one other person present either in the same room or in adjoining room. The person should be competent at the task or activity and familiar with emergency procedures.

High risk activities

Can only be undertaken if there is at least one other person present in the same room, who is competent at the task or activity and familiar with emergency procedures. Suitable emergency arrangements, such as immediate access to a first aid kit must be made.

Laboratories

In the case of laboratories, only authorised persons may enter at any time. Authorised persons would include laboratory employees, students, technicians or visiting researchers and persons of equivalent status who are: Directly associated with the work in the laboratories

Familiar with the layout of the building

Familiar with the emergency procedures

There should be a local policy, procedures and risk assessment in place to cover specifically lone working in the laboratories.

8. Responsibilities

The Health and Safety Office

Will provide advice and training where required on the implementation of this policy, lone working risk assessments and safe systems of work;

Review this policy and associated arrangements at least annually or in the case of an incident occurring where a review may be required.

Directors and Heads of Departments

Shall ensure that:

All employees, students and visitors in their departments are aware of this policy and any local arrangements for lone working.

A risk assessment of lone working for their departments is carried out and that a record is made of this with any control measures that have been identified are implemented accordingly.

Line Managers/Managers

With responsibility for employees who work alone will:

- Ensure that lone working is considered in all risk assessments carried out in their area of responsibility.
- Carry out a risk assessment with the employee(s) to identify and control risks associated with lone working, based on the findings of the risk assessment
- Avoid lone working wherever possible
- Draft the appropriate local department policy/procedure/arrangements for working alone.
- Communicate this policy to all their employees
- Check that appropriate precautions are being taken in accordance with the suggested control measures to reduce risks.
- Ensure that the necessary records are kept e.g. copies of risk assessments on lone working, documented procedure to be followed by lone workers, communication arrangements, supervision etc.
- Carry out a safety training needs analysis of lone workers within their area of work; ensure all relevant employees receive core health and safety training.
- Complete accident reports on behalf of employees or others that are unable to report the accident, incident or dangerous occurrence themselves.
- Telephone the health and safety office immediately if an accident/incident involving an employee working alone appears to come under RIDDOR.

Academic Supervisors of Students/Student Activities

With responsibility for students who may work alone will:

• Apply all of the measures detailed above for line managers with respect to their students.

Employees

Shall ensure that:

- Lone working is avoided wherever possible (outside of a normal office environment).
- They identify any activity carried out by them which will involve them working alone for more than one hour.
- Comply with any precautionary measures including guidelines laid down by managers such as a 'buddy system'.

Employees undertaking academic research must consider the hazards and risks associated with lone working during the study, research or in any field work.

Risk Assessment

All lone working or work activities undertaken outside of normal working hours must be subjected to a risk assessment to consider the risks. The assessment should be carried out by a line manager or supervisor. The Risk assessment should help decide the right level of supervision. There are some high-risk activities where at least one other person may need to be present.

The assessment of the risks to which a lone worker may be exposed must take account of:

- The individual's ability to carry out their activities safely on their own in their environment
- The potential for the individual to be subject to violence

- The individual's ability to request assistance or to withdraw safely from a dangerous situation
- The individual's fitness to carry out the work alone
- Sudden illness or emergencies
- Effects of social isolation
- Risks related to driving
- Fire safety
- Any existing precautionary measures and emergency arrangements

The above list is not exhaustive, each situation is different and individual hazards for those situations must be considered.

Examples of control measures are:

- Prevention of lone working wherever possible
- Suitable training
- Suitable emergency equipment and emergency arrangements
- Adequate supervision
- Defined work activities including written safe systems of work

APPENDIX A
RISK ASSESSMENT CHECKLIST

The risk assessment can be carried out using the University standard risk assessment form but detailed below is a checklist of points to be covered. This list is not exhaustive and each situation can vary. Using the checklist will assist you to determine whether lone working is acceptable within the activity you are risk assessing.

If you are unsure of what is required please seek advice and support from the health and safety office in the first instance.

In the Workplace

1. Does the workplace present a special hazard?
2. Is the access to, or exit from, the workplace safe?
3. Is the lighting and ventilation sufficient?
4. Will other adjacent processes and activities present a risk?
5. Is equipment safe and regularly maintained?
6. What risks will the worker be exposed to in the event of equipment failure?
7. Can substances and goods be handled safely?
8. Does the worker have the appropriate personal protective equipment and are they trained in its use?
9. Has the worker been trained to do the task properly?
10. Has the worker demonstrated his ability to do the task satisfactorily?
11. Is the worker medically fit to undertake the task?
12. Has the worker sufficient information about the job, equipment or substances?
13. Is cash being handled, will they be at a risk of violence?
14. Is the worker known to be reliable and seek help when they reach the limit of their knowledge or experience?
15. What is the appropriate level of supervision for the task?
16. What first aid provision is required?

17. How will you communicate with the worker to ensure his/her wellbeing?
18. What are the arrangements for the worker in the event of an emergency?

Some useful pointers for managers

- Carry out informal inspections of the workplace and access on a regular basis to make sure the workplace is safe and that people are working safely.
- Ask yourself how you would feel working there - would you feel safe?
- Check to make sure equipment is being maintained properly and records are kept.
- Make sure materials safety data sheets are available for all materials used and stored on the premises.
- Make sure risk assessments of all processes and activities are available for workers to refer to and that safe working procedures are available.
- Make sure you know workers are fully aware of local rules, especially those related to "working out of hours".
- Periodically speak to those who work alone informally to find out if they have any concerns that can be dealt with easily.
- Make sure they know you do not want them to put themselves at risk. Ask them how the job could be made safer.
- Make sure you have a reliable system for contacting the lone worker and for establishing they are unharmed – this could be by a call-in system, a tracking device, a mobile phone, etc.
- Consider what emergency situations could arise and make sure you have procedures in place to cover them.

For home visits and meeting the public

Have your lone workers:

1. Been fully trained in strategies for the prevention of violence?
2. Been briefed about the areas where they work, or will work?
3. Been made aware of attitudes, traits or mannerisms that can annoy clients?
4. Been given all available information about the client from all relevant agencies?
5. Understood the importance of previewing cases?
6. Left an itinerary?
7. Made plans to keep in contact with colleagues?
8. The means to contact you – even when the switchboard may not be in use?
9. Got your home telephone number (and you theirs)?
10. A sound grasp of your organisation’s preventative strategy?
11. Authority to arrange an accompanied visit, security escort, or use of a taxi?

Do your lone workers:

1. Carry forms for reporting incidents, including violence or threats of violence?
2. Appreciate the need for this procedure and use it?
3. Know your attitude to premature termination of interviews?
4. Know how to control and defuse potentially violent situations?
5. Appreciate their responsibility for their own safety?
6. Understand the provisions for support by your organisation?

Appendix 6: Participant Consent Form

University of Roehampton London

PARTICIPANT CONSENT FORM

Title of Research Project:

Therapists' experiences of working with male clients with a history of childhood sexual abuse - implications for counselling psychology practice: An Interpretative Phenomenological Analysis

Brief Description of Research Project and What Participation Involves:

This research aims to explore therapists' experiences of working with male clients with a history of Childhood Sexual Abuse and how therapists make sense of their experiences.

This research is looking to interview qualified therapists (counsellors, counselling psychologists, psychotherapists) who:

- Are registered with HCPC, BACP, BPC or UKCP
- Trained in the UK
- As qualified therapists, have worked with at least two male clients with a history of CSA with each for a minimum of six sessions

Eight to ten qualified therapists will be invited to attend an interview in person, which will take place in the service they work at, their private practice, their home, or at the University of Roehampton, depending on the participants' preference. Should the researcher and the participant be unable to meet in person, the interview will be conducted via Skype. During the interview, participants will be asked about their experience of working with male clients with a history of CSA.

Interviews will be audio-recorded and transcribed. Following the interview, participants will be debriefed and encouraged to discuss any thoughts and feelings that have arisen from the interview process. The entire interview and debrief should take no longer than an hour and a half, but might be shorter than this.

Interviews will be confidential within the confines of the research project, and participants will remain anonymous in the write up of this research and in any subsequent publications or presentations. The only exception to treating the participants' identifying information anonymously and confidentially will be if the researcher has serious concerns about risk or harm to participant or others. In such instances, the researcher will contact her supervisor and director of studies, and appropriate steps will be taken to ensure the safety of individual/s at risk.

Investigator Contact Details:

Marta Chromekova
Trainee Counselling Psychologist

Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London SW15 4JD
chromekm@roehampton.ac.uk
Phone: 07913695662

Consent Statement:

I have read and understood the information sheet. I agree to take part in this research, and am aware that I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still be used in a collated form. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

Name …….

Signature ……

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact Prof Mick Cooper.

Director of Studies Contact Details:

Dr Diane Bray
Head of Department
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London SW15 4JD
d.bray@roehampton.ac.uk
+44 (0)20 8392 3627

Prof Mick Cooper Contact Details:

Prof Mick Cooper
Department of Psychology
University of Roehampton
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Holybourne Avenue
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Appendix 7: Ethics Approval Confirmation Email

University of Roehampton London

- Jan Harrison
- Mon 12/09/2016 11:31
- Marta Chromekova (Research Student);
- Amanda Holmes;
- Diane Bray

Dear Marta,

Ethics Application
Applicant: Marta Chromekova
Title: Therapists' experiences of working with male clients with a history of childhood sexual abuse – implications for counselling psychology practice: An Interpretative Phenomenological Analysis
Reference: PSYC 16/ 234
Department: Psychology

Many thanks for your response and the amended documents. Under the procedures agreed by the University Ethics Committee I am pleased to advise you that your Department has confirmed that all conditions for approval of this project have now been met. We do not require anything further in relation to this application.

Please note that on a standalone page or appendix the following phrase should be included in your thesis:

The research for this project was submitted for ethics consideration under the reference PSYC 16/ 234 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 12.09.16.

Please Note:

- **This email confirms that all conditions have been met and thus confirms final ethics approval.**
- **University of Roehampton ethics approval will always be subject to compliance with the University policies and procedures applying at the time when the work takes place. It is your responsibility to ensure that you are familiar and compliant with all such policies and procedures when undertaking your research.**
- **Please advise us if there are any changes to the research during the life of the project. Minor changes can be advised using the Minor Amendments Form on the Ethics Website, but substantial changes may require a new application to be submitted.**

Many thanks,

Jan

Jan Harrison
Ethics Officer
Research Office
University of Roehampton | London | SW15 5PJ
jan.harrison@roehampton.ac.uk| www.roehampton.ac.uk
Tel: +44 (0) 20 8392 5785

Appendix 8: Information Sheet

University of Roehampton London

Information Sheet

Thank you for reading this information sheet. This document will explain why we are doing this research and set out what will be involved for therapists who choose to take part. We appreciate you taking the time to read it, and hope you will be interested in providing support for this research by taking part in it.

The Research Project

This research aims to explore therapists' experiences of working with male clients with a history of Childhood Sexual Abuse (CSA) and how therapists make sense of their experiences. This research seeks to:

- Improve our understanding of the work with male survivors of CSA
- Contribute to a shift in social consciousness and social construction of the male role and acceptance of male children's vulnerability and susceptibility to sexual abuse
- Contribute to growing evidence of the complexity of the subject of male CSA and support the recognition and attention it requires
- Inform therapist training and improve support for professional practices beyond specialist CSA services

Research procedure

This research is looking to interview 8 to 10 qualified therapists (counsellors, counselling psychologists, psychotherapists) with a UK qualification who post-qualification have worked with at least two male clients with a history of CSA with each for a minimum of six sessions.

Therapists will be invited to attend an interview, which will take place in the organisation they work at, their private practice, their home, or at the University of Roehampton, depending on the participants' preference. Should it not be possible to conduct the interview in person, the therapists will be invited to participate in a Skype interview. During the interview, participants will be asked about their experience of working with male clients with a history of CSA.

Interviews will be audio-recorded and transcribed. Following the interview, participants will be debriefed and encouraged to discuss any thoughts and feelings that have arisen from the interview process. The entire interview and debrief should take no longer than an hour and a half, but might be shorter than this.

Interview process and debrief

Therapists will have an opportunity to discuss the research with the researcher before deciding if they want to participate, and after signing a consent form they will

be asked to fill out a simple demographics form. Following the interview, all participants will be debriefed by the researcher. Should further support be required following the debriefing session, participants will be provided with appropriate contact details on the copy of the debrief form they will be offered to keep.

Potential disadvantages/ risks to participants

There are no expected risks for therapists who take part in the study. However, some participants may experience some discomfort answering questions about their work with male clients with CSA history, or inconvenienced at having to give up some of their time to participate in the research. If a participant does experience any discomfort

due to participation in this research, they will be able to miss out questions or to withdraw from the study without providing a reason.

Potential benefits to participants

There is no direct benefit to taking part in this study, although some people find it useful to reflect on their personal and professional experiences leading to better professional efficacy.

The information gathered from this research will contribute towards improving our understanding and provision of counselling services for male clients with CSA history. It will also hope to inform and improve therapist training provisions, thus support better professional practices.

Confidentiality

All information provided will be kept confidential, and will only be accessible to members of the research team. All collection, storage and processing of data will comply with the principles of the Data Protection Act 1998, and has been approved under the procedures of the University of Roehampton Ethics Committee. All the information provided will be stored securely and, where possible, anonymised. Under no circumstances will identifiable responses be provided to any third party. All data included in the publication or presentation of this research, and any subsequent research publications, will be fully anonymised to ensure that no individual is identifiable. Limits to confidentiality will apply in situations where research participants disclose information that they or someone else is at risk of harm. In such situations, it is the ethical obligation of the researcher to follow safeguarding procedures enforced by the service in which the participant is being seen, and where appropriate to disclose information to the appropriate authorities. In such situations, where possible, this will be discussed with participants before a suitable course of action is taken.

Anonymity and data storage

All data generated from this study will be stored securely to the highest possible standard of confidentiality. Transcribed data will be anonymised (meaning all

identifying information will be removed), to ensure that individuals are not identifiable should the research be published.
Anonymised data generated from this study will be stored for an indefinite period following the study, and may be used for publication, presentation, or for subsequent research projects or data analyses. Audio recordings will be destroyed after ten years; in which time, they might be used for other research projects and data analyses (at the discretion of the researcher).

Dissemination of findings
The results of this research study will be written up in partial fulfilment of the requirements for the Doctorate in Counselling Psychology from the University of Roehampton. The results of this research may be published in academic journals, or presented at conferences.

Who is organising the research?
This research is being undertaken by the Department of Psychology at the University of Roehampton. This project has been approved under the procedures of the University of Roehampton's Ethics Committee.
……

If you would be interested in supporting this research, or if you have any further questions, please contact Marta Chromekova (primary investigator):

Marta Chromekova
Trainee Counselling Psychologist

Department of Psychology

Whitelands College
Holybourne Avenue
London
SW15 4JD
Email: chromekm@roehampton.ac.uk

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies). However, if you would like to contact an independent party please contact Prof Mick Cooper.

Director of Studies Contact Details:

Dr Diane Bray
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
d.bray@roehampton.ac.uk
+44 (0)20 8392 3627

Prof Mick Cooper Contact Details:

Prof Mick Cooper
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Holybourne Avenue
London, SW15 4JD
mick.cooper@roehampton.ac.uk
+44 (0)20 8392 3627

Appendix 9: CREST Data Storage and Protection Procedures

University of Roehampton London

CENTRE FOR RESEARCH IN SOCIAL AND PSYCHOLOGICAL TRANSFORMATION (CREST)
DEPARTMENT OF PSYCHOLOGY

DATA STORAGE AND PROTECTION PROCEDURES

Sources

These procedures are informed by, and consistent with, the following sources:

- Roehampton *University Data Protection Policy*, University of Roehampton, May 2010 (revised).
- *Ethical Guidelines for Researching Counselling and Psychotherapy*, British Association of Counselling and Psychotherapy, 2004.
- *Encrypting Confidential Data using Windows XP*, Counselling and Psychotherapy Research Guidelines, Counselling Unit, University of Strathclyde (available via Google Group).
- *Ethical Principles for Conducting Research with Human Participants*, British Psychological Society (accessed Sept. 2008).
- Personal communications with Ralph Weedon, Data Protection Officer, University of Strathclyde

Responsibilities

- The Chief Investigator has overall responsibility to ensure that the appropriate data storage and protection guidelines are followed.

Non-anonymised/personal data

- Non-anonymised (or 'personal') data refers to any form of documentation or media – electronic or otherwise – in which an individual is identifiable. This includes, but is not limited to:
    - signed consent forms
    - client identity forms (including DOB, GP details, gender etc)
    - video recordings

  Note: even if no name or other obvious data is involved that would identify an individual, data such as date of birth, student matriculation number, national insurance number can be 'triangulated', perhaps with other data a third party has acquired, in such a way as to effectively identify someone. Anything that can be used in this way is therefore to be considered personal data.
- Collection of non-anonymised data will be kept to a minimum, and will only be obtained where it is ethically necessary (as in the case of signed consent forms), or where it clearly adds to the scientific value of a project (for instance, the video recording of counselling sessions).

- Non-anonymised data will be kept for ten years.
- All non-anonymised data will be clearly labelled with a date at which it should be destroyed.
- Non-anonymised data will be destroyed in a way which ensures that the data cannot be recovered in any way.
- Non-anonymised data will be kept physically and/or electronically separate from related anonymised data so that links cannot be made between the two sets of data.
- Non-electronic personal data, such as tape recordings and signed consent forms, should be kept in a locked and secure location at all times, and, wherever possible, at the University of Roehampton.
- Electronic personal data will be encrypted and should always be kept on a password protected storage device: wherever possible a PC or network drive located at the University of Roehampton.
- Personal data should not be kept on – or transferred to – laptops, USB sticks, CDs or other mobile/portable devices unless absolutely necessary. As soon as such data is transferred to a secure University location, it must be removed from the portable device such that it cannot be recovered in any way.
- *Should it be necessary to transfer personal data from person to person, this should be done in a secure manner (i.e., by hand or by recorded delivery), always separate from any anonymised data. Any posted materials should be marked 'private and confidential' and sent recorded delivery.*
- For the duration of a study, non-anonymised data may, if absolutely necessary, be stored (in the manner identified above) by investigators other than the Chief Investigator (for instance, where a student is analysing video tapes of counselling sessions). However, on completion of the write-up of the research, all non-anonymised data will be returned to the Chief Investigator for storage, and any copies destroyed.

Anonymised data

- Anonymised data refers to any form of documentation or media – electronic or otherwise – in which an individual is in no way identifiable. This includes, but is not limited to:
    - SPSS spreadsheets in which identifying characteristics (such as age) are not recorded
    - completed questionnaires: qualitative or quantitative
- Anonymised data may be kept for an unlimited period, and may be used for subsequent research projects and data analyses at the discretion of the Chief Investigator (provided that this is made explicit to participants in consent forms).
- Non-electronic anonymised data will be kept in a locked and secure location at all times, ideally at the University of Roehampton.
- Electronic anonymised data may be stored electronically. This should always be to the highest possible standard of confidentiality: for instance, storage in an encrypted folder. It may also be kept on a password protected storage device, ideally at the University of Roehampton and,

wherever possible, will be encrypted. Transfer and storage on portable/mobile devices (such as USB pens) should be kept to a minimum.

- Transfer of anonymised data should be conducted to the highest standards of confidentiality, always separate from any non-anonymised data. Any posted materials should be marked 'private and confidential.' If anonymised data is transferred via email, it should be transferred by the receiver to an encrypted portion of a hard disk as soon as possible, and both sender and receiver should hard delete the email/attachments from their email server.
- For the duration of a study, anonymised data may be stored (in the manner identified above) by investigators other than the Chief Investigator. However, on completion of the write-up of the research, all anonymised data will be returned to the Chief Investigator for storage, and any copies destroyed.

Partially anonymised data (also known as Pseudo-anonymised data)

- This section refers to any form of documentation or media – electronic or otherwise – in which it is highly unlikely that research participants can be identified, but in which the possibility of triangulation exists. This may include, but is not limited to:
    - audio recordings

  Note, if such media includes clearly identifying content (for instance, an interviewee reveals their name or that of their husband on an audio recording), then it will be treated as non-anonymised data until those identifying characteristics are removed.
- Wherever possible, partially anonymised (and non-anonymised) data should be scrutinised and all identifying details should be deleted/erased (for instance, identifying features on transcripts, such as names of partners, should be deleted or blacked out).
- Where all identifying details of partially anonymised data have been deleted/erased, this data will be treated as anonymised data, and subjected to the same procedures as above.
- In instances where partially anonymised data cannot be fully anonymised (for instance, audio recordings in which the participant may be identifiable from their voice), this data will be kept for ten years, and will be stored according to the protocols for non-anonymised data.
- Within this ten-year period, partially anonymised data may be used for subsequent research projects and data analyses at the discretion of the Chief Investigator (provided that this is made explicit to participants in consent forms).

The eight general principles of the data protection act, 1998

- Personal data shall be processed fairly and lawfully (with specific requirements regarding sensitive personal data).

- Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.
- Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
- Personal data shall be accurate and, where necessary, kept up to date.
- Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.
- Personal data shall be processed in accordance with the rights of data subjects.
- Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against loss or destruction of, or damage to, personal data.
- Personal data shall not be transferred to a country or territory outside the European Economic Area, unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Appendix 10: Debrief

University of Roehampton London

Debrief

Thank you for taking part today.

The purpose of this research

Our aim in talking to you today was to find out more about your experiences of working with male clients with a history of Childhood Sexual Abuse (CSA) and about how you make sense of your experiences.

The information gathered from this research will contribute towards improving our understanding and the provision of counselling services for male clients with a CSA history. It will also hope to inform and advance therapist training provisions and in turn help to improve professional practices across all services working with this client group.

Post-interview debrief

Sometimes during an interview, people get thoughts, feelings, concerns, or questions that they want to talk about.

It is important that you have the chance to reflect on the interview, and to take a moment to consider whether there is anything you would like to talk about. The following questions might help you to do this:

- How do you feel having completed the interview?
- How did it feel to be interviewed?
- Has the interview brought any thoughts of feelings up for you?
- Do you have any questions or concerns about the interview process, or about what happens next?
- Do you think there were any questions I should have asked that I did not?
- Do you have any other ideas about how to make the interview better?
- Is there anything else you would like to share at this point?

Thank you for your contribution to this research, and I hope you enjoyed taking part.

If you think of any questions you would like to ask following the interview, you can contact me via the contact details below:

Marta Chromekova
Trainee Counselling Psychologist

Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
Phone: 07913695662

Please note: If you are worried about any aspect of this study, or have any other questions please contact Dr Diane Bray, Director of Studies at the University of Roehampton. However, if you would rather talk to someone at the university who is not directly involved in the research, you can contact Prof Mick Cooper.

Director of Studies Contact Details:

Dr Diane Bray
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Prof Mick Cooper Contact Details:

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mick.cooper@roehampton.ac.uk
+44 (0)20 8392 3627

Should you require further support, please contact one of the following organisations:

Samaritans – 0845 790 9090
Support Line – 0170 876 5200
Sane Line – 0845 767 8000

Appendix 11: Example of Analysed Transcript

1 Interviewer: Could you tell me how did you come to work with um male clients with CSA?

Lucy: Um, well I saw a job advertised for [organisation's name] and um, I was quite interested in the work and I think partly 'cause really in this profession you don't get to work with men as much as with women and I really enjoyed my work with men when I've been working in other settings. Um, so I was quite interested in the role um working with men and I had worked with a client before who'd had um, who'd been abused as a child and I remembered just finding the work quite interesting and um the client really showing a very childlike part of them in the work and I think I just had responded. I really found it quite interesting, something um quite maternal in me had come out. So yeah, I was interested in the job, um but also the hours, you know the practicality of working here was, worked out well. Um, so, yeah, I've been here for nearly three years.

Interviewer: So, it was... what interested you was very much that child...childlike self that came out?

Lucy: Yes, and I think often, I found, working with male clients, I, I guess it is this whole interesting thing about male and masculinity and what society decides that should be. And I think, I had seen clients who were men who'd come into the room acting the man in a very kind of, you know, narrow definition of what a man is and then actually through the work seeing this very vulnerable, childlike, um quite delicate side. And I think I quite liked that juxtaposition. I just have, I guess someone's humanity, doesn't matter what gender, whatever definition, you know, their humanity um and yeah, I just found that quite rewarding and quite um interesting.

Interviewer: So, it was quite um I suppose quite two

different sides to the person that came into the room, with that conception of masculinity (Lucy: Yes) **as it is known within our society and the um contradiction of seeing the... that's not all there is** (Lucy: yeah).

Lucy: Yeah, seeing the bigger picture, in the whole ,the more holistic view and I do wonder, I've got three sons **(Interviewer: alright)** and I do wonder whether that was an element as well, just seeing them grow up and there is some stereotypical behaviours they do and then other times not at all and I think perhaps that sort of opened my mind as well to not falling into stereotypes and being open to the whole person.

Interviewer: And have you, how have you found working with them, with, with male clients, with the... with male survivors as a therapist?

Lucy: Um, I found it really rewarding, very painful, very painful what many of them been through um and not just the whatever the sexual incidents had been, just the um, shaking their very foundations of who they are as a person and their identity and just, just how major the impact is um across all aspects of their life. Um so yeah, very traumatic at times, um and I feel quite um protective of them, um and there's also a lot of complex issues um with very traumatised individuals so people will um not commit or they don't want to talk about the sexual abuse, they'll come some weeks and not others and just, that's kind of really having to challenge me to be thinking about what it is they need and that the intimacy of the therapy is sometimes too much and trying to kind of go with them in a way not just strict: "you will be here, you will talk to me for fifty minutes and we will talk about the abuse", you know just really having to go with what um they need, teaching them, allowing them some kind of a

Being a mother of 3 boys

Stereotypes vs. seeing the whole person

profound impact of the CSA

Being protective

Trauma in the therapy room

Too close

The challenges of meeting the clients' needs

contrasting views of men
stereotypical perceptions

becoming more open minded about her views of men through her personal & professional experiences of men through seeing the vulnerable side of them too

- emphasises the enormity of the impact their experiences have had on their life & on their identity
- it's painful being a witness to this
- this impact plays out in the counselling relationship too
- the intimacy of the therapeutic relationship is overwhelming for the clients
- the challenge of meeting the client's needs
- adapting to & respecting their needs

Impact - so it's not just the past experience of the abuse but the IMPACT of it

self-regulation and respecting that.

Interviewer: Ok. And how have you found working with them in terms of you being a female, so being somebody of the opposite sex?

Lucy: Um, I was talking actually to my line manager about this, 'cause I was wondering, people can request either a female or a male counsellor when they come here um and I was actually asking whether do more people request female than male? And actually it's about half and half. So, I only ever see um clients who've asked for a female, um often who've been abused by male but not always. I've had couple who've had um female perpetrators. Um, I, I think it brings out in me something quite maternal um and that in itself may be difficult for some clients who've been abused by their mother. Um, but I think maybe also in some ways this whole issue about seeing the client as a human being sometimes it just transcends gender. So, I am not always thinking, oh I am a woman I, I am different from you, I don't think I've ever thought that. So, I haven't really felt it as a, as a big difference.

Interviewer: Does it? Whilst overall, you may, sometimes you forget about it, it's not in the room as such but if for example you've mentioned that um some of your clients have been abused by females, close relatives, females, does that come, does that impact on your, your experience?

Lucy: From my experience?

Interviewer: Mm

Lucy: Um, I think it makes me think - how can a mother do that? Um, and then I may explore with a client how it feels telling me, a woman about that. Um, but generally that kind of level of trust and connection has sort of been made. Um, so, a client hasn't, I

Counsellor's gender is client's choice

- Curiosity about client's choices of their counsellor's gender
- As likely to request men as women

Feeling maternal

- maternal reaction

Transcending gender

- transcending gender
- not being aware of gender difference

- difficulty understanding how a mother could abuse their child
- ability to explore relationship dynamics with the therapist once trust have been established

haven't had a client tell me that has been a problem and I guess with people where it might have been a problem would have already deselected themselves by requesting a male counsellor in a way um but I know they've said on the... even the receptionist who's the admin, who's a male, some people will phone up and say: "I can't even talk to you". They don't want to talk to a man. So, even at that point, um, but I think in the room possibly because of choices they've made, the clients have seemed happy to talk about the abuse and I haven't been seen as abusive because I am a female, mm.

Interviewer: So, it's very important as in any therapy but to have that to build that relationship to be able to (Lucy: yeah, trust) to trust

Lucy: And particularly with men, I mean 'cause we used to offer two years because research has shown that for men it took longer to often open up. And I've certainly seen that in my client work. Um, it took one of my clients about 9 months to be able to actually talk about the abuse and luckily we had two years. But then the funding was cut and now it's only a year. So we'd, we would've had three months of actually doing work on the abuse. So, um yeah, I think it's really important to kind of bear that in mind how long it can take and particularly for people where their trust has been so horrendously broken, um those kind of building rapport sessions, and, you know, for the clients to see that you are trustworthy, yeah, mm.

Interviewer: And maybe with, with clients who particularly suffered some form of trauma and abuse that trust, the fact that they're able to learn to trust you, I wonder what, what, what is that like for you?

Lucy: It's a well, it can be huge, it can be really hugely

- clients having a choice between female & male therapists
- the choice eliminates problem with the therapist's gender

Significance of building trust

- offering longer therapy for men due to greater difficulty opening up - to build trust

Accommodating to men's needs in the therapy room

- the impact of funding cuts need of attributing greater level of support to men - due to prolonged disclosure times

Funding cuts impeding the therapy process

- the significance of creating a safe space ie. through providing the time needed for men to have the time to build trust with the therapist

TIME → TRUST → HEALING

Acknowledging men's difficulty to open up by providing more time

Trust & sense of safety

important, um I was just thinking about one client, where we worked together for two years and I could see how then our relationship and the fact that he trusted me and he showed himself, showed who he was, his jokey side, his more confident side, that he didn't feel he could outside but then gradually he started to outside, and I think seeing that um that it was safe for him to show a part of him um and then for him to start doing that outside was just hugely important but that was a client I worked with for two years, you know it took time and I think referrals through the NHS and stuff, there isn't a time for that so then often charities that kind of have to pick up those clients that wouldn't get support elsewhere. So, I guess that's the work in a way, is the relationship um and enabling a client to be seen, their whole, I guess it's going back to that the whole kind of picture of a person.

Interviewer: I suppose that takes me to what... are there any challenges of working with, with male clients of childhood sexual abuse in your experience?

challenge to engage

Lucy: Um, I think, some of the challenges are engagement. Um and I work face to face, but we've also started doing telephone counselling and that's been quite interesting because some clients they... sometimes for physical reasons or geography, they couldn't get here. It opened up a way of, of contact, which has been helpful. But also for some clients that cannot bear the shame of sitting opposite someone and telling what's happened to them. So, the telephone counselling I think has helped some clients. And I had one client who just couldn't commit to the coming here, it was too hard for him, I mean there were times when he would, I mean he was diagnosed with psychosis, but sometimes he just couldn't be here. I mean he was here in

adapting the service to clients needs

shame as a barrier to support

severe mental health diff. as a barrier

the transformational power of trust & feeling safe in the therapy room

the importance of being able to work long-term with clients

the work lies in the relationship

ENGAGEMENT A CHALLENGE

- telephone counselling a new form of contact - service more accessible
- ADAPTING TO CLIENTS' NEEDS
- overwhelming shame as a barrier to direct therapeutic contact
- Severe mental health difficulties as a barrier to -iv-

person, but not mentally. Um, but then we started offering
telephone and he did engage weekly for about three months
which was hugely important. Um, but yeah, that's one of the
challenges, it's the engagement. But we're trying to be as flexible
as we can be here and we do online as well, um and I think for
some people who when the abuse, the sexual abuse is combined
with just a total undermining of who, who they are, their sense of
themselves, their fear in some way that they are soiled and
tainted and um in some way have been responsible for what
happened to them. I mean their sense of self is, can be just
absolutely destroyed and, and obviously that can be really hard
to work with um particularly when they don't come, so you can't
do the work. I think that's probably the biggest challenge. I think
once they're here I can kind of work, I feel like I can work with
what they bring. But it's just that getting them through the door
and then making them feel safe so that they can start to engage
with the process. I think that's probably what I find as one of the
biggest challenges. Um, I think when I first started here just
hearing about the abuse, where it happened, um parents not
being aware that it was happening. I think I found that just really,
really sad and that, that was hard. Um, all these children that
were, were just no one noticed that something was going so
badly wrong and I think that kind of, yeah, there is a, there is a
sadness there. I feel sad um for them and that is so happens in
society. I mean at the moment with about the footballers coming
out, you know, I think it's good that it is coming out, people are
more aware this happens. It's not just tiny section of society. Um,
but I think it's something also quite people are in denial and I
think um working here, not that I was in denial before but there's
some, sometimes there's very brutal realities that can make you

Sexual abuse overtaking the person's identity

turning up is the biggest challenge

making them feel safe enough to stay

Processing the client's stories - challenging

Sadness

raising awareness

denial - defending against brutal realities that could otherwise taint ones worldview

- telephone contact / online a new opportunity / means to support clients
- the sexual abuse overtaking their whole identity
- destroyed sense of self makes the work very difficult - particularly when not turning up
- the initial phase of attending & building trust is most challenging.
- When first started - difficult to cope with sadness brought on by CSA stories.

SADNESS

Celebrity disclosures of CSA raising awareness.

denial in society

realities of CSA more present through the work

becoming more real

6

having a balanced perspective

Leaving the stories behind

think that the world is horrible place to be, but it's not, there are horrible things that happen (Interviewer: yeah) and that is just really important to get that balance and we've had quite a bit of training here and training on vicarious traumatisation 'cause when you're hearing horrible um stories all the time, you do need to self-care um yeah and kind of leave it at work so I guess those are the kind of challenges.

Interviewer: I suppose I was wondering, 'cause you've mentioned quite a few in terms of the challenges of what, what can come up and the difficulty maybe of working with the clients if they don't turn up or you know, how to manage that. And I wonder whether you can think of maybe one particular client and what, how did you experience that challenge of...

Lucy: What? Of them not turning up?

Interviewer: yeah, or anything that you... maybe something that you mostly felt challenged with or found most difficult?

Lucy: I think the client that I did see face to face and then we changed to a... to telephone. I found him quite challenging because he had some quite serious mental health difficulties with the psychosis and um I wasn't always quite sure when I was talking to him whether he was, kind of what state he was in. Um and he was also just brutally in the most horrible situation um being a refugee, waiting to be deported, engaging in more kind of an abusive, you know with the whole... that was quite whole systemic, the whole, the whole of society was just kind of letting him down and I found that really challenging because one person for one hour a week, what...what can you do? Um, you can do... that's all you can do, just be there and trying, I was just trying to be constant and just hear, hear his grievances and how unhappy

difficulty of meeting a client with serious mental health issues

the limitations of therapy

Skimming against the stream

the realities of CSA skewing the world view
finding a balance in perception

Self-care to maintain a balanced outlook on the world & prevent traumatisation through exposure to stories about abuse

VERY SO CHALLENGING

the challenges of working with serious mental health issues

difficulty of meeting the client

The limitations of the therapy

The challenges of supporting the client whilst being let down by [redacted] society

Trying to hold on to the client all alone whilst the whole society is pulling him down

7

limitations of therapy
sense of helplessness
staying with

Boundaries

staying with

repeatedly let down / let down by the system

he was and... But I found it quite challenging 'cause part of me was thinking um he needs to be sectioned, he needs his mum and dad living with him, looking after him, nurturing him and that wasn't gonna happen. Um, so I guess it was just having to sit with his chaos and the chaos of society and the situation and that was quite hard. And I worried, I worried about him a lot. Um, but I think there was also something about needing to realise there is a service, there is a limit on what we can do and as a Counselling Psychologist there is a limit on what I can do. I can't go around to his house and sit with him and give him all the love that he needed from his mum and dad and ~~weren't, wasn't~~ getting and yeah it was challenging. I guess knowing what the limit was and the boundaries, cause he would, he pushed the boundaries as well. Um, so yeah, yeah that was a challenging... that was a challenging one. And then, and then he just disappeared. One time he just didn't call and so I didn't know if he'd been deported, I didn't know if he died, ~~I didn't know if he~~ ended up in hospital I you know and then just having to sit with that.

Interviewer: That must have been very difficult

Lucy: Yeah and that's how some of our clients kind of are. That's their world really, quite a worldly place. Um, people that really should be looked after by the NHS I think really. Um you know, and have a full care package, but sometimes I think charities just end up picking up people that have fallen through the net.

Interviewer: And I suppose that also comes with the uncertainty of, of not, well the knowledge that you can't do everything for them and the uncertainty of like that particularly client when they disappeared from the radar not knowing what will happen to them and what has happened to them.

- knowing the client's needs yet remaining helpless
- The difficulty of staying with
- Worrying!
- Realising her limitations
- Difficulty staying with the limitations / bounds of the therapy room
- Remaining boundaried despite being tested
- The powerlessness of not knowing
- Staying with uncertainty
- The complexity of clients difficulties
- Clients lacking the required care / support

Lucy: Mm, yeah, yeah and probably never knowing. He might re-
refer, he might be back in [name of the country] I don't know or
he might... something, he might have died, I really, I really don't
know. But his chaos was um... was really hard for him and I felt in
our sessions, sometimes I got a flavour of that chaos and it
wasn't nice, it wasn't nice. Um but there were so many things
about his environment, society that were playing into that chaos, I
think.

Interviewer: When you say that you got a flavour of it, can you tell me a bit more?

Lucy: Um, just sometimes feeling "what's going on?
What's going on?" You know. "What's real? What's not real?"
(smiling) And he would talk about his telephone telling him to do
things and um, instructions to do things and really trying to work
out what, what is it that he is telling me and sometimes I would
be unclear about whether he was saying he'd been told to do
something, or he'd done it, um and I think that was partly about
his presentation, partly his English and yeah, me just being left
sometimes at the end of the session thinking - What? What is
real? What has happened? and What hasn't happened? and
What he imagined? or What he's fearful of? and just being very
um, chaotic and confused. I'd be confused um, and then it helped
obviously with supervision and talking to the clinic services
director about how, how we're going to manage this um and he
did actually have a social worker, so making contact with the
social worker and trying to tie up his care a little bit. Even for this
social worker, this client would just go off the radar. Um but it
would help I mean I think, if I was working privately with him that
would've been a real, real challenge. But as part of the
organisation I was held a bit, which enabled me to hold him a

Why ?
Experiencing the client's chaos
Society as a perpetuator of the client's chaos
What is real & what isn't?
Uncertainty
Why
Being left with uncertainty
The support of supervision
Shared experience
Held by the organisation

bit more um, but yeah it was confusing.
Interviewer: So it's quite important to have that support or that like the organisation to, to hold you?
Lucy: Absolutely and good supervision. That's what you really need. Good supervision. Who understands about this client group. Because it can be quite um... I think it's partly the trauma and partly the chaos and then the fact that in therapy there is an intimacy and intimacy has been totally abused in the past so having to keep the boundaries ~~but also to~~ be flexible and acknowledge: I am a human being, you're a human being and that we all have a connection. But that does need close monitoring in a way because the clients have just been so um abused. That's been abused in the past that kind of relationship.
Interviewer: I am wondering how... whether you have noticed any changes in your work with this client group from maybe when you started to now? 'Cause you have had some extensive experience working with this group.
Lucy: Um (pauses) I think with this client group I've had to (pauses) face some of my biggest fears as a practitioner. (Interviewer: Mm). Um, so I've had a client who committed suicide. I've had um my notes called for court. 'Cause obviously, lots of our clients are then going to court and you know they're taking their abuser to court. Um, and obviously, well obviously, the suicide is just yeah horrible. But I've also been fearful about the notes being shared and stuff like that. So, in some ways I've had to kind of confront I guess my worst fears as a practitioner. Um, but I think it made me braver in some ways. I mean you have to listen to harrowing stories but yet some of the clients, probably most of the clients I've seen, have kind of managed to hold on to hope. So even despite everything that's happened

Feeling supported & = understood

Finding the right balance

Creating & maintaining a safe space

her biggest Facing fears

Holding onto hope

Support that understands

Having to create the right balance for the client BALANCE

Responsibility of creating a safe environment

(the therapist's) Facing her biggest fears

The nature of the client group forces to confront her biggest fears

Growing braver

Hope

they can still feel like a hopeful element - there is a future that they can look forward to. Just thinking recently about a client who I've had him for two years, who initially... he struggled to leave the house, he felt everything was his fault um and then gradually he just became more confident, um more able to relate, more able to place the abuse and the responsibility where it belonged not his, wasn't his stuff. It was the abuser and um and about a month after we finished he sent a postcard from [name of country] he travelled to [name of country]. It was just like: "Oh my God!" So, just seeing that despite the kind of misery where he was he found a path to hope. And I think in some ways, I guess that does feed into my practice that however much someone is in despair, there can be um... there can be hope. There can be a better future. Um, and I think that has had an impact on, on me. Um, yeah, maybe I am braver, yeah I am braver. I haven't thought about that but yeah, I feel more able to deal with what is thrown at me. Um, and it does feel like this work is looking at something that society has tend to, tended to turn away from or deny, perhaps less so now, maybe that's perhaps it's changing as, as we speak, maybe, I don't know. Um, so yeah, probably braver. Um, but also really respectful of even in the depths of despair someone can find something to hold onto and um yeah kind of move forward. Yeah.

Interviewer: And in terms of that how has your own meaning making process of, of working with this client group changed if, if it has at all?

Lucy: So my meaning making process of...

Interviewer: Of working with this client group. So, so how do you experience it? How do you make sense of what is going on for them? Whether that has changed over time,

transformation

hope

empowered by the clients

overcoming CSA legacies

transformation from despair to hope

finding a path to hope

client's hope feeding into therapist's practice - positive impact on therapist - feeling braver & more capable

empowerment - feeling more capable

respecting the clients' ability to overcome their legacy.

from when you started?

Lucy: I think there is something about, I've been able to hold on to hope (Interviewer: Mm), because I've kind of seen it. So, I can hold it on, hold on to it for new clients coming who seem like there is no hope. Um, something I also wonder about, is whether they need to talk about the abuse. That's something that I am wondering at the moment. Um, I think generally people do, but I don't know that that's absolute. I think for some people, they don't... they might not need to go over the abuse and the actual incidences and what happened and the detail. But sometimes it's the stuff around the abuse. So, when they did first disclose and it was dismissed. When they did try and tell their parents but it was just not dealt with. Sometimes that has been harder than actually what happened. Um and I think perhaps, when I initially started working here, I maybe had the assumption that you must talk about the abuse at some point. We must talk about it in detail. And I am...I am not sure. This is still, it's something I am still wondering. Um, but it has been interesting to me - I am thinking of another client now, who said that it wasn't the abuse that was the worst thing for him. It was the fact that he was so young and someone else saw it and they reported it and the teacher got sacked and then it was all the other teachers then turned on him - to blame him. So it's the bullying after more than the abuse. And that was something I hadn't really thought. So, that's kind of a learning thing for me. Um and I guess, thinking existentially or phenomenologically, thinking horizontalisation. You know, don't assume you know what the worst thing is for the client. Um and yeah, that's been an important learning curve for me. Hmm, and I guess a reminder of work... trying to work phenomenologically and see what comes up for the, for the client.

Holding onto hope

- ability to hold on to hope (presentation)
- not giving up on clients whose situation appears hopeless

Clients' needs

- Re-evaluating held assumptions about clients' needs
- Need for full disclosure questioned
- learning from working with clients
- failure to protect & support greater than abuse itself
- failure to validate abuse experiences experienced as traumatic

Re-evaluating assumptions held

Clients' stories as a reminder to refrain from making assumptions about their experiences

Interviewer: I wonder whether there is anything else that you think it would be helpful for me to know, something maybe that I didn't think of? Something...

Lucy: Ok, I am just wondering about what, what kind a led you into this research and what you were if you had any hopes for what you were wanting to kind of find or anything or what you were looking for?

Interviewer: Um, I got into this research, I got interested in um, um sort of the therapist's experiences of... Well, initially, I started looking at um the abuse that, that males go through and that was I had one client in my um placement that, that was sexually abused and that was very new to me in, in that sort of one to one counselling work. So that's what sort of opened up thoughts around it as well as, I had a friend of mine who was um sexually abused. (Lucy: right). So, I had these two experiences, one from a personal life and one from a professional one. I suppose more this one to one counselling work that made me wonder what it must be like for them? Because it didn't come up for very long time. And, and then I started wondering that it must be very different for them as it is for females and I started looking into it and there is so much more support and, and knowledge and understanding of what is it like for females (Lucy: yeah). Even in the media it is much more openly talked about. There is more support whilst with males, it still seems to be far behind sort of the support that females and the acknowledgement and understanding, so it's quite...

Lucy: I think that in society there is still a lot of denial, even when I say where I work they're like: "What"? Well, how does that work?" Especially if the perpetrator, the perpetrator is a woman.

Denial
Shaming

denial in society about male CSA - shaming for men

(Interviewer: yeah). It brings up a lot of things of: "Well, how can that be?" That's so shaming for the, for the man, for the client. Um and I think it does bring up a lot about the definitions of masculinity and femininity and actually, I would say I am a feminist and I like challenging some of these stereotypes and actually some of those theories have been quite helpful with challenging the definitions of masculinity as well. Who decides that? Who, who says that? I mean, um but yeah that does, that does give an extra layer for lot of the clients, an extra layer of difficulty and then wondering if... so I've had clients who would define themselves as straight but were abused by a man and then it's made them wonder: "Am I gay?" So this whole thing about sexual orientation. Um, I've had clients who, who will say that they're gay but then they'll think that it is because of the abuse. Wherein an actual fact they might have, that might have been their sexual orientation anyway, but then that becomes so tainted with the abuse. So, then for them to try and go out into the world and have a healthy sexual gay relationship is so fraught with difficulties because it brings up the abuse. So, they can't even find out about their own sexuality, so it's just brings up so many difficulties and I, I guess those would be the key things; the sexual, the impact on, on your own sexuality and how you connect to other people in a sexual relationship. Um, but this sense of kind of feel kind of responsible. It's a big thing in our client work. I mean, who's responsibility is it? Twelve year old boy or a thirty year old man? I mean, I mean common, let's... But sometimes it's so ingrained in their way of thinking that they were to blame that they did something, they were asking for it. I mean, yeah. And I think society perhaps doesn't help with, with that. Um and I guess also, for a lot of people that has been abused,

- denial about male CSA - reflective of societal conceptions of masculinity & femininity -
- the impact of societal conceptions of masculinity on men
- challenging stereotypes as a/from a feministic point of view
- usefulness of feminist theories in shaming challenging mainstream definitions of masculinity
- questioning of sexual orientation as a consequence of being abused

feminist theories helpful in challenging the definitions of masculinity

Masculinity

Impact of CSA on sexual identity

sexual identity tainted by the abuse

Self-blame

self-blame for being abused

RESPONSIBILITY

need for / the role of psychoeducation

they're body has reacted. There has been some physical arousal during the abuse and they think: "Therefore, I, I wanted it". But it's not the same, it's not the same as wanting it. And there is sometimes a... kind of a sexual psychoeducation that needs to happen in the therapy as well that you know a twelve year old boy is full of hormones, you're getting an erection, that's ok, it doesn't mean that, that is what you want, it's something you chose to do that with an older man or an older woman and... Um yeah I guess these are some of the kind of... just thinking of the themes that come up um and yeah and just kind of a sense of feeling tainted um that their introduction to the sexual world has happened younger than it would have and was forced upon them. Not, you know, children explore, they find out things, they touch each other, you know that happens (Interviewer: Yeah) but when it's an older person coming in and deciding, you know, it's just, it kind of just leaves such a, it can kind of stunt their sexual growth in a way. Um, yeah. But it's, it's really, can be really rewarding, really rewarding work um and quite harrowing. Yeah, I think there is something about the way that I experience it. I feel like I've seen some, I've heard some of the most horrific things, I thought I could, um and it has made me braver because I've seen how they've, the clients have kind of faced it and I've seen the, the path you can move on, it can happen. Yeah. I am just trying to think, what other kind of issues come up, what else would be useful. Um, there is a very good book, I don't know if you've read Alan Corbet's book? It was a supervisor who's recommended it, who is so experienced. He's actually left now, but I would really recommend it. It's like one of the few books on male CSA survivors. There aren't, there aren't many out there. Um, but he talks quite a bit about society's kind of reaction and

becoming braver

need for psychoeducation in therapy

the impact of the abuse on

SEXUALISED PREMATURELY

rewarding & harrowing
her experience unique to her
grew braver in the face of her clients' stories by witnessing their resilience & ability to overcome

why is this a great big unspoken thing (Interviewer: thank you) some doesn't want to know about so... Yeah, ok do you feel like you've got everything you need?

Interviewer: I think so, sorry, just look at the time, just. Um (pauses) I suppose, there's you mentioned in terms of sort of taking care of yourself and the vicarious traumatisation that you maybe have been supported here with or trained as well. Um, could you tell me a bit more about that?

Lucy: Um, yeah. Um, just, I mean we had training, it was actually by our supervisor just sort of highlighting the fact that I mean it's the same with any trauma work - if you're constantly listening to harrowing stories, it can have a big impact on you. Um, we kind of in the training we just thought about what we needed to do to leave it behind in a way. Um and one of the things that came up for me it was that I realised by leaving here and getting the tube home that in itself is some... it, it was a real leaving it behind, but it was quite symbolic as well. Getting the train, quiet time by the time I got home, I kind of left it behind. Um, but there's still clients will kind of play on my mind and um I find the supervision here really helpful. We're able to go to a supervisor whenever we want to. So if something is really playing on our mind, we're worried about, risk um that really helps and I guess just making sure that you have other stuff out of, out of work. And I was seeing at one point, I was seeing six clients in a row here and it was too much I had to cut down 'cause I was just finding it very, very heavy. Um and I think another impact that has had on me, having children of my own um I am probably verging on (snickers) paranoid about who looks after them and extracurricular activities and things like that. So, it had an impact um personally and just seeing how clever and manipulative some paedophiles can be, I guess. So,

received training on vicarious traumatisation

Learning to leave [redacted] work behind

Leaving work behind

Cannot completely forget about about the work

The support of supervision

Finding supervision very helpful - always available for support

Balance between work & life

Impact of CSA work on personal life

Seeing too many clients in a row can be overwhelming

Impact on her sense of (over) protectiveness of her children

impact

that's had an impact but it's an education. But, um also remembering, you have to remember the percentage of people that it happens to you know still relatively small. Although, reading the paper at the moment, you wouldn't necessarily think that. Um, so yeah, just about support from supervisor, having a break from work. Um, yeah I guess that's kind of important self-care, which would be the same I guess in any sort of counselling environment but I do feel particularly here and probably particularly also in trauma organisations. 'Cause sometimes the organisations can sometimes start acting out some of the trauma um and become a little bit 'ooh' itself. So, just making sure the organisation is grounded and... We had a bit of chaos with the funding two years ago, which has got cut and that was really, really traumatic because we were having to tell clients that we don't know whether we can carry on um and that was really quite destabilising. So, um as I think with any organisation that deals with trauma you need the basics for working with someone who has, who's been traumatised. You need the basics of safety, home, food, you know the basics to be able to do the rest and that felt really shaky as we were really having to hold the clients, even though all the counselling team were feeling really shaky. Um, so yeah, things like that, just being kind of mindful of, of the importance of the basics.

Interviewer: How did that? Um, how ...I suppose it have had an impact on you in terms of that unsettledness that was created by, by the (Lucy: funding?) cuts? Yeah.

Lucy: It was really, really unsettling and then it felt for months - this is my experience by I know other counsellors had it too - I felt like I was having to hold the clients and protect them from this chaos and then actually once the funding came back in...I think it

self-care

support

Impact of funding cuts

holding the clients

support + break
self-care - greater emphasis on in trauma work

risk of organisations not managing / handling well the work - acting out

importance of organisations being grounded

funding cuts put them in a position of destabilising the client work

importance of the basics being in place when working with trauma clients

keeping it together for the clients holding them

Impact of lack of holding on the therapist

Impact on the counsellor

Holding

holding the client

was a delay...then it kind of hit me and that's when I was thinking I can't deal with six clients in a row, it's too much. So, it was after the funding crisis was over and I've held it all together that it kind of hit me and then I was like: "I need to cut down my hours". So, it was quite interesting to see that delayed, the knock on effect, um of the funding and things are calm now we have a new chief exec and structures in place um but it is partly the way of charities at the moment. They get funding for a year and then you are straight onto getting your next set of funding and that's really unsettling. Um, and we, the counsellors, have to be settled to do the work, we have to feel grounded. Um so, it was a hard decision for me to cut down on my clients. I've never finished early with clients before. Um that was a really hard decision, but I need... I needed to. Um, so yeah I guess that's another thing about self-care knowing what, what your capacity is. Um, and I perhaps think some of the clients here are more challenging than other places where I've worked. I've worked in primary care before um and I worked in [organisation's name] before, and [organisation's name] - there were some quite challenging clients as well. Um, but yeah, you need to be, you do need to be held definitely.

Interviewer: Do you feel; and this is quite hypothetical; but if the funding would not have been cut, do you feel that you would have felt the need to cut down the clients? Is that...

Lucy: Maybe not as much, maybe not as much. I mean some other things happened in my life. My dad had died and I was just getting really tired with the kids because I was seeing people in the evenings. So, there were other elements too but, but I think that really impacted. I think it did really impact. Um, because I'd kind a worked so hard to be stable for the clients and kind of

once the clients were safe, she started to struggle → delayed experience

organisation is stable now

uncertainty around the charities stability due to the way they're funded

the way of funding interfers with the counsellors ability to be grounded

discomfort around putting herself first her needs being in conflict with her clients' needs

the significance of being held

managing destabilisation in various aspects of life at the same time - personal & professional

putting a lot of effort into being stable for the client

work with male CSA

protecting the client

keeping the chaos behind, because I knew particularly for one or two clients, they would have just disintegrated really. It would have just felt like another kind of... a betrayal or I don't know something. It would have tapped into something really that had been damaged already for them, I think, of people in authority letting you down or um things that should be safe weren't. I mean that is a huge thing for people who had been abused: "Why wasn't I looked after? There's people who should have been um taking responsibility". And so yeah, I think that did have a big impact, yeah. Mm. But yeah, it's, it is all stable now until next, until the next funding crisis (snickers) unfortunately. Unfortunately, there's just not enough money to go around. And in a way I guess, when all the football stories that are coming out now, I mean sadly, but I mean that may have an impact on getting more funding. It seems to be how it works, when things are kind of high profile in the media, um, yeah. 'Cause we've got a lot of referrals after all this JS stuff and the football referrals is half of the month, since whatever has come out about the footballers, it's doubled. Um, but yeah, but ideally a charity has kind of consistent money and that can build on. Safe, consistent referrals and lengths of time for counselling I think. But that doesn't always happen like that. Mm.

Interviewer: If you haven't got anything else to add then...

Lucy: I'd bet I can think of something on the way...

Appendix 12: Example of List of Emergent Themes

Participant Lucy: Initial Emergent Themes:

Interest in working with men

Lucy 1:4 *I was quite interested in the work and I think partly 'cause really in this profession you don't get to work with men as much as with women and I really enjoyed my work with men when I've been working in other settings.*

Lucy 1:8 *I had worked with a client before who'd had um, who'd been abused as a child and I remembered just finding the work quite interesting*

Maternal - protective

Lucy: 1:10 *the client really showing a very childlike part of them in the work and I think I just had responded, I really found it quite interesting, something um quite maternal in me had come out.*

Lucy 2:50 *um and I feel quite um protective of them*

Lucy 3:71 *I've had couple who've had um female perpetrators. Um, I, I think it brings out in me something quite maternal.*

Lucy 19:539 I'd kind a worked so hard to be stable for the clients and kind of keeping the chaos behind, because I knew particularly for one or two clients, they would have just disintegrated really.

Societal navigation of masculinity

Lucy 1:19 *I guess it is this whole interesting thing about male and masculinity and what society decides that should be.*

Male juxtaposition - seeing the whole person

Lucy 1:21 *I had seen clients who were men who'd come into the room acting the man in a very kind of, you know, narrow definition of what a man is and then actually through the work seeing this very vulnerable, childlike, um quite delicate side.*

Lucy 2:36 *I've got three sons* ***(Interviewer: alright)*** *and I do wonder whether that was an element as well, just seeing them grow up and there is some stereotypical behaviours they do and then other times not at all and I think perhaps that sort of opened my mind as well to not falling into stereotypes and being open to the whole person.*

Lucy 3:74 *Um, but I think maybe also in some ways this whole issue about seeing the client as a human being sometimes it just transcends gender.*

Lucy 5:132 *that's the work in a way, is the relationship um and enabling a client to be seen, their whole, I guess it's going back to that the whole kind of picture of a person.*

Impact of CSA work

Lucy 2:45 *I found it really rewarding, very painful, very painful*

Lucy 2:50 *very traumatic at times*

Lucy 6:169 *hearing about the abuse, where it happened, um parents not being aware that it was happening. I think I found that just really, really sad and that, that was hard.*

Lucy 8:216 *I worried, I worried about him a lot.*

Lucy 11:311 *And I think in some ways, I guess that does feed into my practice that however much someone is in despair, there can be um... there can be hope. There can be a better future. Um, and I think that has had an impact on, on me. Um, yeah, maybe I am braver, yeah I am braver. I haven't thought about that but yeah, I feel more able to deal with what is thrown at me.*

Lucy 11:320 *Um, so yeah, probably braver. Um, but also really respectful of even in the depths of despair someone can find something to hold onto and um yeah kind of move forward. Yeah.*

Lucy 15:437 *it's really, can be really rewarding, really rewarding work um and quite harrowing. Yeah, I think there is something about the way that I experience it. I feel like I've seen some, I've heard some of the most horrific things, I thought I could, um and it has made me braver because I've seen how they've, the clients have kind of faced it and I've seen the, the path you can move on, it can happen.*

Lucy 17:476 *I think another impact that has had on me, having children of my own um I am probably verging on (snickers) paranoid about who looks after them and extracurricular activities and things like that. So, it had an impact um personally and just seeing how clever and manipulative some paedophiles can be, I guess. So, that's had an impact but it's an education.*

Impact of CSA

Lucy 2:47 *shaking their very foundations of who they are as a person and their identity and just, just how major the impact is um across all aspects of their life.*

Lucy 6:155 *for some people who when the abuse, the sexual abuse is combined with just a total undermining of who, who they are, their sense of themselves, their fear in some way that they are soiled and tainted and um in some way have been responsible for what happened to them.*

Lucy 14:400 *I've had clients who would define themselves as straight but were abused by a man and then it's made them wonder: "Am I gay?" So this whole thing about sexual orientation. Um, I've had clients who, who will say that they're gay but then they'll think that it is because of the abuse.*

Lucy 14:410 *it's just brings up so many difficulties and I, I guess those would be the key things; the sexual, the impact on, on your own sexuality and how you connect to other people in a sexual relationship.*

Lucy 14:413 *this sense of kind of feel kind of responsible. It's a big thing in our client work..... sometimes it's so ingrained in their way of thinking that they were to blame that they did something, they were asking for it.*

Challenges of working with CSA

Lucy 2:52 *people will um not commit or they don't want to talk about the sexual abuse, they'll come some weeks and not others*

Lucy 5:139 *I think, some of the challenges are engagement.*

Lucy 6: 160 *their sense of self is, can be just absolutely destroyed and, and obviously that can be really hard to work with um particularly when they don't come, so you can't do the work. I think that's probably the biggest challenge.*

Lucy 6:165 *But it's just that getting them through the door and then making them feel safe so that they can start to engage with the process. I think that's probably what I find as one of the biggest challenges.*

Lucy 7:199 *I found him quite challenging because he had some quite serious mental health difficulties with the psychosis and um I wasn't always quite sure when I was talking to him whether he was, kind of what state he was in.*

Challenges of meeting clients' needs

Lucy 2:54 *that's kind of really having to challenge me to be thinking about what it is they need and that the intimacy of the therapy is sometimes too much and trying to kind of go with them in a way not just strict: "you will be here, you will talk to me for fifty minutes and we will talk about the abuse", you know just really having to go with what um they need, teaching them, allowing them some kind of a self-regulation and respecting that.*

Lucy 3:104 *we used to offer two years because research has shown that for men it took longer to often open up. And I've certainly seen that in my client work. Um, it took one of my clients about 9 months to be able to actually talk about the abuse and luckily we had two years. But then the funding was cut and now it's only a year. So we'd, we would've had three months of actually doing work on the abuse.*

Lucy 7:209 *that's all you can do, just be there and trying, I was just trying to be constant and just hear, hear his grievances and how unhappy he was and...*

Lucy 8:214 it was just having to sit with his chaos and the chaos of society and the situation and that was quite hard.

Time to trust

Lucy 3:111 *I think it's really important to kind of bear that in mind how long it can take and particularly for people where their trust has been so horrendously broken, um those kind of building rapport sessions, and, you know, for the clients to see that you are trustworthy, yeah, mm.*

Lucy 4:121 *I was just thinking about one client, where we worked together for two years and I could see how then our relationship and the fact that he trusted me and he showed himself, showed who he was, his jokey side, his more confident side, that he didn't feel he could outside but then gradually he started to outside, and I think seeing that um that it was safe for him to show a part of him um and then for him to start doing that outside was just hugely important but that was a client I worked with for two years, you know it took time*

Overcoming barriers to support / Adapting to clients' needs

Lucy 5:140 *we've also started doing telephone counselling and that's been quite interesting because some clients they... sometimes for physical reasons or geography, they couldn't get here. It opened up a way of, of contact, which has been helpful.*

Lucy 5:144 *But also for some clients that cannot bear the **shame** of sitting opposite someone and telling what's happened to them. So, the telephone counselling I think has helped some clients.*

Lucy 5:147 *I had one client who just couldn't commit to the coming here, it was too hard for him, I mean there were times when he would, I mean he was diagnosed with psychosis, but sometimes he just couldn't be here. I mean he was here in person, but not mentally. Um, but then we started offering telephone and he did engage weekly for about three months which was hugely important.*

Lucy 6:154 *But we're trying to be as flexible as we can be here and we do online as well*

Rising awareness

Lucy 6:175 *at the moment with about the footballers coming out, you know, I think it's good that it is coming out, people are more aware this happens. It's not just tiny section of society.*

Denial as a defence against brutal realities (challenges)

Lucy 6:178 *I think it's something also quite people are in denial and I think um working here, not that I was in denial before but there's some, sometimes there's very brutal realities*

Lucy 11:317 *it does feel like this work is looking at something that society has tend to, tended to turn away from or deny, perhaps less so now*

Lucy 13:388 *I think that in society there is still a lot of denial, even when I say where I work they're like: "What"? Well, how does that work?" Especially if the perpetrator, the perpetrator is a woman. It brings up a lot of things of: "Well, how can that be?"*

Balanced perspective (challenges)

Lucy 7:181 *there are horrible things that happen (Interviewer: yeah) and that is just really important to get that balance*

Self-care

Lucy 7:185 *when you're hearing horrible um stories all the time, you do need to self-care um yeah and kind of leave it at work*

Lucy 16:464 *Um and one of the things that came up for me it was that I realised by leaving here and getting the tube home that in itself is some... it, it was a real leaving it behind, but it was quite symbolic as well. Getting the train, quiet time by the time I got home, I kind of left it behind. Um, but there's still clients will kind of play on my mind*

Lucy 17:485 *having a break from work. Um, yeah I guess that's kind of important self-care, which would be the same I guess in any sort of counselling environment but I do feel particularly here and probably particularly also in trauma organisations.*

Lucy 18:521 *Um so, it was a hard decision for me to cut down on my clients. I've never finished early with clients before. Um that was a really hard decision, but I need... I needed to. Um, so yeah I guess that's another thing about self-care knowing what, what your capacity is.*

The system

Lucy 7:205 *that was quite whole systemic, the whole, the whole of society was just kind of letting him down and I found that really challenging because one person for one hour a week, what...what can you do?*

Lucy 9:246 *there were so many things about his environment, society that were playing into that chaos, I think.*

Lucy 19:545 *I think, of people in authority letting you down or um things that should be safe weren't.*

Limitations of the therapist role

Lucy 8:217 *there was also something about needing to realise there is a service, there is a limit on what we can do and as a Counselling Psychologist there is a limit on what I can do. I can't go around to his house and sit with him and give him all the love that he needed from his mum and dad and weren't, wasn't getting and yeah it was challenging. I guess knowing what the limit was and the boundaries, cause he would, he pushed the boundaries as well.*

Sitting with the unknown

Lucy 8:225 *And then, and then he just disappeared. One time he just didn't call and so I didn't know if he'd been deported, I didn't know if he died, I didn't know if he ended up in hospital I you know and then just having to sit with that.*

Lucy 9:259 *What? What is real? What has happened? and What hasn't happened? and What he imagined? or What he's fearful of? and just being very um, chaotic and confused.*

Support and holding

Lucy 9:262 *I'd be confused um, and then it helped obviously with supervision and talking to the clinic services director about how, how we're going to manage this*

Lucy: 9:269 as part of the organisation I was held a bit, which enabled me to hold him a bit more um, but yeah it was confusing.

Lucy 10:274 *good supervision. That's what you really need. Good supervision. Who understands about this client group.*

Lucy 16:469 *I find the supervision here really helpful. We're able to go to a supervisor whenever we want to. So if something is really playing on our mind, we're worried about, risk um that really helps and I guess just making sure that you have other stuff out of, out of work.*

Lucy 18:530 *you need to be, you do need to be held definitely.*

Boundaries

Lucy 10:277 *in therapy there is an intimacy and intimacy has been totally abused in the past so having to keep the boundaries but also to be flexible and acknowledge: I am a human being, you're a human being and that we all have a connection. But that does need close monitoring in a way because the clients have just been so um abused. That's been abused in the past that kind of relationship.*

Facing practitioner's biggest fears

Lucy 10:290 *I've had a client who committed suicide. I've had um my notes called for court. 'Cause obviously, lots of our clients are then going to court and you know they're taking their abuser to court. Um, and obviously, well obviously, the suicide is just yeah horrible. But I've also been fearful about the notes being shared and stuff like that.*

Holding onto hope

Lucy 10:297 *you have to listen to harrowing stories but yet some of the clients, probably most of the clients I've seen, have kind of managed to hold on to hope.*

Lucy 11:302 *client who I've had him for two years, who initially... he struggled to leave the house, he felt everything was his fault um and then gradually he just*

became more confident, um more able to relate, more able to place the abuse and the responsibility where it belonged not his, wasn't his stuff. It was the abuser and um and about a month after we finished he sent a postcard from [name of country] he travelled to [name of country]. It was just like: "Oh my God!" So, just seeing that despite the kind of misery where he was he found a path to hope.

Lucy 12:332 *I think there is something about, I've been able to hold on to hope, because I've kind of seen it. So, I can hold it on, hold on to it for new clients coming who seem like there is no hope.*

Assumptions

Lucy 12:344 *I think perhaps, when I initially started working here, I maybe had the assumption that you must talk about the abuse at some point. We must talk about it in detail. And I am...I am not sure. This is still, it's something I am still wondering.*

Lucy 12:353 *So it's the bullying after more than the abuse. And that was something I hadn't really thought. So, that's kind of a learning thing for me.*

Lucy 12:356 *You know, don't assume you know what the worst thing is for the client. Um and yeah, that's been an important learning curve for me.*

Not being believed

Lucy 12:340 *But sometimes it's the stuff around the abuse. So, when they did first disclose and it was dismissed. When they did try and tell their parents but it was just not dealt with. Sometimes that has been harder than actually what happened.*

Lucy 12:348 *I am thinking of another client now, who said that it wasn't the abuse that was the worst thing for him. It was the fact that he was so young and someone else saw it and they reported it and the teacher got sacked and then it was all the other teachers then turned on him to blame him.*

Challenging stereotypes

Lucy 14:394 *I would say I am a feminist and I like challenging some of these stereotypes and actually some of those theories have been quite helpful with challenging the definitions of masculinity as well.*

The role of psychoeducation

Lucy 14:420 *for a lot of people that has been abused, they're body has reacted. There has been some physical arousal during the abuse and they think: "Therefore,*

I, I wanted it". But it's not the same, it's not the same as wanting it. And there is sometimes a... kind of a sexual psychoeducation that needs to happen in the therapy

Heaviness of the work

Lucy 16:473 *I was seeing at one point, I was seeing six clients in a row here and it was too much I had to cut down 'cause I was just finding it very, very heavy.*

The impact of cutbacks

Lucy 17:491 *making sure the organisation is grounded and... We had a bit of chaos with the funding two years ago, which has got cut and that was really, really traumatic because we were having to tell clients that we don't know whether we can carry on um and that was really quite destabilising. So, um as I think with any organisation that deals with trauma you need the basics for working with someone who has, who's been traumatised. You need the basics of safety, home, food, you know the basics to be able to do the rest and that felt really shaky as we were really having to hold the clients, even though all the counselling team were feeling really shaky.*

Lucy 18:507 *It was really, really unsettling and then it felt for months - this is my experience by I know other counsellors had it too - I felt like I was having to hold the clients and protect them from this chaos and then actually once the funding came back in...I think it was a delay...then it kind of hit me and that's when I was thinking I can't deal with six clients in a row, it's too much. So, it was after the funding crisis was over and I've held it all together that it kind of hit me and then I was like: "I need to cut down my hours". So, it was quite interesting to see that delayed, the knock on effect um of the funding and things are calm now we have a new chief exec and structures in place um but it is partly the way of charities at the moment.*

Media's influence

Lucy 19:553 *when all the football stories that are coming out now, I mean sadly, but I mean that may have an impact on getting more funding. It seems to be how it works, when things are kind of high profile in the media, um, yeah. 'Cause we've got a lot of referrals after all this JS stuff and the football referrals is half of the month, since whatever has come out about the footballers, it's doubled.*

Appendix 13: Example of Theme Clusters from Individual Transcript

Participant Lucy: Themes and Sub-Themes

Theme 1 - Therapist vs Society

Sub-theme 1: Seeing the whole person

Lucy 1:21 *I had seen clients who were men who'd come into the room acting the man in a very kind of, you know, narrow definition of what a man is and then actually through the work seeing this very vulnerable, childlike, um quite delicate side.*

Lucy 2:36 *I've got three sons and I do wonder whether that was an element as well, just seeing them grow up and there is some stereotypical behaviours they do and then other times not at all and I think perhaps that sort of opened my mind as well to not falling into stereotypes and being open to the whole person.*

Lucy 3:74 *Um, but I think maybe also in some ways this whole issue about seeing the client as a human being sometimes it just transcends gender.*

Lucy 5:132 *that's the work in a way, is the relationship um and enabling a client to be seen, their whole, I guess it's going back to that the whole kind of picture of a person.*

Sub-theme 2: Protective

Lucy: 1:10 *the client really showing a very childlike part of them in the work and I think I just had responded, I really found it quite interesting, something um quite maternal in me had come out.*

Lucy 2:50 *um and I feel quite um protective of them*

Lucy 3:71 *I've had couple who've had um female perpetrators. Um, I, I think it brings out in me something quite maternal.*

Lucy 8:216 *I worried, I worried about him a lot.*

Lucy 19:539 *I'd kind a worked so hard to be stable for the clients and kind of keeping the chaos behind, because I knew particularly for one or two clients, they would have just disintegrated really.*

Sub-theme 3: Being let down

Lucy 7:205 *that was quite whole systemic, the whole, the whole of society was just kind of letting him down and I found that really challenging because one person for one hour a week, what...what can you do?*

Lucy 9:246 *there were so many things about his environment, society that were playing into that chaos, I think.*

Lucy 19:545 *I think, of people in authority letting you down or um things that should be safe weren't.*

Sub-theme 4: Denial as a defence

Lucy 6:178 *I think it's something also quite people are in denial and I think um working here, not that I was in denial before but there's some, sometimes there's very brutal realities*

Lucy 11:317 *it does feel like this work is looking at something that society has tend to, tended to turn away from or deny, perhaps less so now*

Lucy 13:388 *I think that in society there is still a lot of denial, even when I say where I work they're like: "What"? Well, how does that work?" Especially if the perpetrator, the perpetrator is a woman. It brings up a lot of things of: "Well, how can that be?"*

Theme 2 - Challenges

Sub-theme 1: The challenges of 'meeting' the clients

Lucy 2:52 *people will um not commit or they don't want to talk about the sexual abuse, they'll come some weeks and not others and just, that's kind of really having to challenge me to be thinking about what it is they need and that the intimacy of the therapy is sometimes too much and trying to kind of go with them in a way not just strict: "you will be here, you will talk to me for fifty minutes and we will talk about the abuse", you know just really having to go with what um they need, teaching them, allowing them some kind of a self-regulation and respecting that.*

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Lucy 6: 160 *their sense of self is, can be just absolutely destroyed and, and obviously that can be really hard to work with um particularly when they don't come, so you can't do the work. I think that's probably the biggest challenge.*

Lucy 6:165 *But it's just that getting them through the door and then making them feel safe so that they can start to engage with the process. I think that's probably what I find as one of the biggest challenges.*

Lucy 7:199 *I found him quite challenging because he had some quite serious mental health difficulties with the psychosis and um I wasn't always quite sure when I was talking to him whether he was, kind of what state he was in.*

Sub-theme 2: The challenges of staying with

Lucy 7:209 *that's all you can do, just be there and trying, I was just trying to be constant and just hear, hear his grievances and how unhappy he was and...*

Lucy 8:214 it was just having to sit with his chaos and the chaos of society and the situation and that was quite hard.

Lucy 8:225 *And then, and then he just disappeared. One time he just didn't call and so I didn't know if he'd been deported, I didn't know if he died, I didn't know if he ended up in hospital I you know and then just having to sit with that.*

Lucy 9:259 *What? What is real? What has happened? and What hasn't happened? and What he imagined? or What he's fearful of? and just being very um, chaotic and confused.*

Sub-theme 3: Overcoming barriers

Lucy 5:140 *we've also started doing telephone counselling and that's been quite interesting because some clients they... sometimes for physical reasons or geography, they couldn't get here. It opened up a way of, of contact, which has been helpful.*

Lucy 5:144 *But also for some clients that cannot bear the shame of sitting opposite someone and telling what's happened to them. So, the telephone counselling I think has helped some clients.*

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Lucy 6:154 *But we're trying to be as flexible as we can be here and we do online as well*

Theme 3 - Stability

Sub-theme 1: Time

Lucy 3:104 *we used to offer two years because research has shown that for men it took longer to often open up. And I've certainly seen that in my client work. Um, it took one of my clients about 9 months to be able to actually talk about the abuse and luckily we had two years. But then the funding was cut and now it's only a year. So we'd, we would've had three months of actually doing work on the abuse.*

Lucy 3:111 *I think it's really important to kind of bear that in mind how long it can take and particularly for people where their trust has been so horrendously broken, um those kind of building rapport sessions, and, you know, for the clients to see that you are trustworthy, yeah, mm.*

Lucy 4:121 *I was just thinking about one client, where we worked together for two years and I could see how then our relationship and the fact that he trusted me and he showed himself, showed who he was, his jokey side, his more confident side, that he didn't feel he could outside but then gradually he started to outside, and I think seeing that um that it was safe for him to show a part of him um and then for him*

to start doing that outside was just hugely important but that was a client I worked with for two years, you know it took time

Sub-theme 2: Funding cuts / Destabilisation

Lucy 17:491 *making sure the organisation is grounded and... We had a bit of chaos with the funding two years ago, which has got cut and that was really, really traumatic because we were having to tell clients that we don't know whether we can carry on um and that was really quite destabilising. So, um as I think with any organisation that deals with trauma you need the basics for working with someone who has, who's been traumatised. You need the basics of safety, home, food, you know the basics to be able to do the rest and that felt really shaky as we were really having to hold the clients, even though all the counselling team were feeling really shaky.*

Lucy 18:507 *It was really, really unsettling and then it felt for months - this is my experience by I know other counsellors had it too - I felt like I was having to hold the clients and protect them from this chaos and then actually once the funding came back in...I think it was a delay...then it kind of hit me and that's when I was thinking I can't deal with six clients in a row, it's too much. So, it was after the funding crisis was over and I've held it all together that it kind of hit me and then I was like: "I need to cut down my hours". So, it was quite interesting to see that delayed, the knock on effect um of the funding and things are calm now we have a new chief exec and structures in place um but it is partly the way of charities at the moment.*

Sub-theme 3: Holding

Lucy 9:262 *I'd be confused um, and then it helped obviously with supervision and talking to the clinic services director about how, how we're going to manage this*

Lucy: 9:269 as part of the organisation I was held a bit, which enabled me to hold him a bit more um, but yeah it was confusing.

Lucy 10:274 *good supervision. That's what you really need. Good supervision. Who understands about this client group.*

Lucy 16:469 *I find the supervision here really helpful. We're able to go to a supervisor whenever we want to. So if something is really playing on our mind, we're worried about, risk um that really helps and I guess just making sure that you have other stuff out of, out of work.*

Lucy 18:530 *you need to be, you do need to be held definitely.*

Sub-theme 4: Self-care

Lucy 7:185 *when you're hearing horrible um stories all the time, you do need to self-care um yeah and kind of leave it at work*

Lucy 16:464 *Um and one of the things that came up for me it was that I realised by leaving here and getting the tube home that in itself is some... it, it was a real*

leaving it behind, but it was quite symbolic as well. Getting the train, quiet time by the time I got home, I kind of left it behind. Um, but there's still clients will kind of play on my mind

Lucy 16:473 *I was seeing at one point, I was seeing six clients in a row here and it was too much I had to cut down 'cause I was just finding it very, very heavy.*

Lucy 17:485 *having a break from work. Um, yeah I guess that's kind of important self-care, which would be the same I guess in any sort of counselling environment but I do feel particularly here and probably particularly also in trauma organisations.*

Lucy 18:521 *Um so, it was a hard decision for me to cut down on my clients. I've never finished early with clients before. Um that was a really hard decision, but I need... I needed to. Um, so yeah I guess that's another thing about self-care knowing what, what your capacity is.*

Theme 4 - Impact

Sub-theme 1: Challenging

Lucy 2:45 *I found it really rewarding, very painful, very painful*

Lucy 2:50 *very traumatic at times*

Lucy 6:169 *hearing about the abuse, where it happened, um parents not being aware that it was happening. I think I found that just really, really sad and that, that was hard.*

Sub-theme 2: Finding a balanced perspective

Lucy 7:181 *there are horrible things that happen (Interviewer: yeah) and that is just really important to get that balance*

Lucy 8:217 *there was also something about needing to realise there is a service, there is a limit on what we can do and as a Counselling Psychologist there is a limit on what I can do. I can't go around to his house and sit with him and give him all the love that he needed from his mum and dad and weren't, wasn't getting and yeah it was challenging. I guess knowing what the limit was and the boundaries*

Lucy 17:476 *I think another impact that has had on me, having children of my own um I am probably verging on (snickers) paranoid about who looks after them and extracurricular activities and things like that. So, it had an impact um personally and just seeing how clever and manipulative some paedophiles can be, I guess. So, that's had an impact but it's an education. But, um also remembering, you have to remember the percentage of people that it happens to you know still relatively small. Although, reading the paper at the moment, you wouldn't necessarily think that.*

Sub-theme 3: Hope and Bravery

Lucy 11:311 *And I think in some ways, I guess that does feed into my practice that however much someone is in despair, there can be um... there can be hope. There can be a better future. Um, and I think that has had an impact on, on me. Um, yeah, maybe I am braver, yeah I am braver. I haven't thought about that but yeah, I feel more able to deal with what is thrown at me.*

Lucy 11:320 *Um, so yeah, probably braver. Um, but also really respectful of even in the depths of despair someone can find something to hold onto and um yeah kind of move forward. Yeah.*

Lucy 15:437 *it's really, can be really rewarding, really rewarding work um and quite harrowing. Yeah, I think there is something about the way that I experience it. I feel like I've seen some, I've heard some of the most horrific things, I thought I could, um and it has made me braver because I've seen how they've, the clients have kind of faced it and I've seen the, the path you can move on, it can happen.*

Lucy 10:297 *you have to listen to harrowing stories but yet some of the clients, probably most of the clients I've seen, have kind of managed to hold on to hope.*

Lucy 11:302 *client who I've had him for two years, who initially... he struggled to leave the house, he felt everything was his fault um and then gradually he just became more confident, um more able to relate, more able to place the abuse and the responsibility where it belonged not his, wasn't his stuff. It was the abuser and um and about a month after we finished he sent a postcard from [name of country] he travelled to [name of country]. It was just like: "Oh my God!" So, just seeing that despite the kind of misery where he was he found a path to hope.*

Lucy 12:332 *I think there is something about, I've been able to hold on to hope, because I've kind of seen it. So, I can hold it on, hold on to it for new clients coming who seem like there is no hope.*